Business Office (802) 241-2214
Commissioner's Office (802) 241-2610
ICS Division (802) 241-2639
Legal Division (802) 241-2602
Fax Number (802) 241-1129
TTY Relay Service 1-800-253-0191

Developmental Services Division (802) 241-2614
Fax Number (802) 241-4224
Mental Health Division (802) 241-2604
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State of Vermont

Agency of Human Services
Department of Developmental & Mental Health Services
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Division of Mental Health Services

MEDICAID FEE-F0R-SERVICE PROCEDURES MANUAL

Revised and Notified July 1, 2003

EFFECTIVE January 1, 2004

This document is the Vermont Division of Mental Health's updated Medicaid Provider Manual. The rules and regulations outlined in this manual supercede those in the manual dated January 1, 2001.

Table of Contents

PNMI's are defined. This section summarizes what mental health services can be provided beyond what the PNMI includes in its per diem rate. Complete PNMI regulations can be obtained from the Department of Social & Rehabilitation Services. PNMI rates are per diem rates and duplicate billing to Medicaid by Designated Agencies is not allowed.

INTRODUCTION

Medicaid is Title XIX of the Social Security Act. It is a matching entitlement program which provides medical care to aged, blind, or disabled persons and low income families with limited resources. An individual's eligibility for Medicaid is determined by the Department of Prevention, Assistance, Transition and Health Access (PATH).

The July 1, 2003 Medicaid Manual revisions that follow are a provider's reference manual detailing those mental health services offered through the Vermont Division of Mental Health's Medicaid Program for fee-for-service for traditional Medicaid recipients. The revisions are intended to provide guidance to designated community mental health centers regarding eligible service activity, procedures for billing, and documentation requirements.

The manual format identifies eligible mental health **covered services** under the State Medicaid Plan and general **definition**, minimum and/or maximum **limits** for the service category, eligible **provider qualifications**, and **documentation requirements**. **Rates** are published periodically in memorandums and arrive as separate communications. The Fee for Service for Traditional Medicaid Manual identifies eligible **location codes**, consistent with Medicare location codes, for billed service activity. **Cost Centers** and **MCIS Service Codes** are identified for services reporting to the Department of Developmental and Mental Health Services. Additionally, a **Procedure Code for Medicaid Billing** is identified for billing services to EDS Medicaid for reimbursement. Lastly, **clarifications** regarding the most frequently asked questions or identified issues related to accurate billing are made available for reference.

Provider numbers are issued for the provision of specific types of services such as mental health services, developmental services, services in a detoxification facility, neurological services or general medical services. Only those services specifically allowed under a given provider number will be reimbursed. In cases where multiple provider numbers are issued to a Designated Agency, Department of Developmental and Mental Health Services (DDMHS) staff will have access to settlement sheets documenting payments under each number. Ongoing Medicaid auditing by DDMHS will include verification that double payments are not made under multiple provider numbers for the same service.

The manual contents do not represent an inclusive reference directory for all possible questions or clarifications that may be necessary to comply with Medicaid requirements. Providers are responsible for seeking clarification regarding services or activities and eligibility for reimbursement when service or billing is in question. As a general principle, when in doubt about provisions contained in this provider manual, seek written clarification from DDMHS before billing. Please submit questions in writing to the Commissioner of DDMHS, or his/her designee.

These procedures are subject to change. Revisions will occur on as "as needed" basis. Except for rate changes, this document and clarification memos will be the only mechanism for reflecting change. Therefore, from time to time you will be receiving new pages or memos for insertion into this manual.

SECTION I

ADULT

MEDICAID FEE-FOR-SERVICE

TRADITIONAL MEDICAID RECIPIENTS

CLINICAL AND SUPPORT SERVICES

ADULT CLINICAL AND SUPPORT SERVICES

1. Eligible Providers

An entity is considered enrolled for participation in the Medicaid program when it is a designated agency and has a signed contract with DDMHS for the services identified in this manual or is otherwise authorized by the Commissioner of the Department of Developmental and Mental Health Services. If the Designated Agency subcontracts services to be performed under this signed contract, it is the responsibility of the Designated Agency to ensure that the subcontractor adheres to the requirements set forth in this manual. The subcontractor is then able to perform these services on behalf of the Designated Agency. An entity may also be designated and enrolled for participation in the Medicaid program if otherwise authorized by the Commissioner of the Department of Developmental and Mental Health Services.

❖ **Eligibility for Participation:**

Medicaid payment for covered services is limited to Commissioner designated agencies (community mental health centers) and other Commissioner designated entities that are established for the purpose of providing community-based mental health care. In order for a Commissioner designated agency or entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements of the Commissioner of Developmental and Mental Health Services pursuant to 18 VSA, Chapter 177, Section 7401(2), (4), and (15); and 18 VSA, Chapter 207, Sections 8907 through 8913.

- The service must be either provided directly by a Vermont Medicaid enrolled physician affiliated with the designated agency, or prescribed by a physician or authorized advanced practice nurse practitioner directly affiliated with the designated agency and provided by a staff member who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director of the designated agency as competent to provide the service.

- The service must have been delivered by a sub-contractor, the Designated Agency itself, or an entity otherwise authorized by the Commissioner of Developmental and Mental Health Services and provided by a qualified staff member who, based on his/her education, training, or experience is authorized by the prescribing physician or Medical Director of the designated agency as competent to provide the service.

❖ **Commissioner Designated Agency/Entities:** Billing is allowed only for services provided by:

- Qualified staff who are employed by a designated agency/entity;

- Students/interns, provided that the student/intern is supervised by a qualified staff of the designated agency/entity, is subject to all designated agency/entity policies and procedures, and that the designated agency/entity and the supervising physician assume responsibility for the work performed.

❖ **Designated Agency/Entity Sub-Contractors:** Entities or individuals working under sub-contract for a designated agency/entity acts as an employee of the designated agency/entity for purposes of billing Title XIX services. Sub-contracts must be available for review by Title XIX auditors. Sub-contracts require provisions showing:

- With whom the sub-contract is made, stating specific individuals and their credentials;

- What specific Title XIX services the sub-contractor will provide under the sub-contract;

- The staff member responsible for monitoring billing practices of the sub-contractor;

- The staff member responsible for providing supervision over the clinical practices of the sub-contractor (with the exception of contract physicians).

2. Service Prescription, Documentation and General Clarifications

Individual Plan of Care

Every Medicaid eligible individual must have an Individual Plan of Care (IPC). The IPC is directly related to assessments and must encompass, at a minimum, the services prescribed and provided by the designated agency to the individual. It must contain the following components:

- **Goals:** A statement of the mutually desired overall, long range results of interventions expressed in the individual's words as much as possible.

- **Objectives:** A statement of the specific individual skills and/or community resources that need to be changed or modified to achieve each goal. Objectives are to be stated in observable and measurable terms.

- **Interventions:** A description of the interventions to be used to achieve each objective including:
  - The staff position or service component responsible;
  - The intervention activity (Medicaid modality);
  - The frequency of the activity (measurable). PRN or "as needed" frequency should be reserved for emergent or episodic service delivery. It is acceptable to identify a range of treatment frequency for planned services or interventions. Such treatment or service delivery changes may be substantiated in clinical notes, subsequent quarterly reviews, or IPC addendums.

- **Outcomes:** The anticipated outcome resulting from the treatment and/or services provided for the identified goal.

At a minimum, the plan must be signed by the primary clinician or case manager, the physician or authorized advanced practice nurse practitioner, and whenever possible, the individual. Any other team member providing treatment should be encouraged to review and sign the individual plan of care.

Prescription

- ❖ Prescription is a physician's authorization of treatment as indicated by the physician's signature on an Individual Plan of Care.

- ❖ Prescription is an authorized advanced practice registered nurse's (APRN) authorization of treatment as indicated by the APRN's signature on an Individual Plan of Care.

- ❖ Treatment and service modalities, with the exception of emergent treatment needs and services, must be prescribed in the Individual Plan of Care or subsequent addendums for the period in which the treatment and service modalities is provided to be eligible for reimbursement. Emergency treatment needs and services may be prescribed as PRN or "as needed" services, but do not need to be prescribed as planned services. IPCs should prescribe services <u>that you intend to deliver</u> (not every possible option). (see Field Questions and Clarifications Section VIII)

- ❖ For mental health services, "prescription of an individual plan of care" must be obtained prior to the fourth reimbursed service.

Prescription Review

Individual Plans of Care (IPC's) must be developed annually (total rewrite) with physician or authorized APRN signature and reviewed quarterly unless the individual's condition and/or treatment needs change; necessitating the addition, deletion, or modification of prescribed interventions. An addendum is required if services have a sustained pattern of change. Addendums, representing a prescriptive change, require physician or authorized APRN signature. At a minimum, the quarterly review (every 90 days from a complete, annual IPC) and routine prescription must be indicated by the physician's or APRN's signature. IPC's should be completed prior to the fourth reimbursed service (Note: emergency care services are exempt from this requirement).

IPC Clarifications

Checklists of services or treatment modalities by themselves do not constitute individual plans of care. Additional notes are required to explain the information that has been "checked off".

The individual should be directly involved in establishing his/her IPC to the extent possible. It is not required that the individual be present when the IPC is updated.

If an individual has not had services for six months or the individual plan of care or quarterly review recommends the IPC be closed, then the case must be considered closed. Individual's requesting services after six months from the date of their last service should be considered new to services and must have a new plan of care prescribed. A new Diagnostic Assessment should be considered following a period of non-service or significant change in clinical presentation. In such cases, an addendum or update to information is acceptable if a comprehensive assessment was completed within the previous six months.

General Record Keeping Requirements

Documentation of services provided must be legible, of sufficient clarity, and sufficient clinical content (minimum required content is specified for each service) to ensure eligibility for payment. Auditors must be able to read the service documentation.

All clinical and support notes must include:

- Identification of the individual served;
- The date the service was rendered;
- The specific title or code of the service rendered;
- Location in which the service occurred;
- The amount of time it took to deliver the service;
- Reference to the treatment goal for the service;
- Summary of the service rendered with appropriate clinical content (refer to specific service documentation requirements);
- Who rendered the service (signature). (see Clarifications this section)
- Title and qualifications of the service provider. If not required by the agency, qualifications, degrees and titles must be on file at the designated agency and provided during audit.

If co-therapists are involved in treatment, either may sign the progress note.

Each reimbursed service must be documented in the individual's case record. This documentation may be in another provider's files but must be available to Title XIX auditors and identified with the individual's name and/or record number.

The use of white-out in the clinical record is prohibited. The use of cross-outs to alter information that has been entered into the clinical record is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alterations.

Checklists by themselves are not acceptable as clinical or support notes. Additional narrative is required to explain the information that has been "checked off".

A time sheet serves as the source document for Medicaid billing. Time sheet information must match billing and the individual's clinical record data. The time sheet must include:

- Identification of the individual
- Staff member identification
- Signature of staff member
- Program and cost center
- Service (Medicaid modality)
- Duration
- Date
- Number of individuals receiving service present
- Location
- If other staff are present (time sheets may need to be reviewed during an audit)

Clarifications:

Typically, who rendered the service refers to the written signature of the individual treater. A printed signature for verification purposes is inadequate. Agencies, requesting and demonstrating appropriate safeguards for use of computer generated signatures, may be authorized to use electronic signature technology if policies and procedures for the agency are submitted and approved by DDMHS.

3. Clinical Assessment (DIAGNOSIS AND EVALUATION)

Definition:

Clinical Assessment services evaluate across environments individual and family strengths, needs, existence and severity of disability (ies) and functioning. A clinical assessment is a service related to identifying the extent of an individual's condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the individual's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory, and orientation; an evaluation of the individual's social situation relating to family background, family interaction and current living situation; an evaluation of the individual's social performance, community living skills, self-care skills and prevocational skills; an evaluation of the support system's and community's strengths and availability to the individual and family; and/or an evaluation of strategies, goals and objectives included in the development of a service plan.

Clinical Assessment or reassessment must be a face-to-face contact.

Limits:

Clinical Assessment is a "pay as billed" one unit service up to the allowable limits of four units of service annually. Each clinical assessment is considered one unit in its entirety. Reimbursement is limited to a minimum of one-half (1/2) hour sessions. The sum of time spent on the clinical assessment is billed as one unit and the re-imbursement rate is calculated based on the fee schedule for 15 minute increments. There is no set dollar amount for a clinical assessment, the service will be "paid as billed" according to the time spent in 15 minute intervals. The Clinical Assessment limits may be adjusted based on a case-by-case review by the Department of Developmental and Mental Health Services of supporting information from the Designated Agency. Prior written authorization is required for any extended services.

Staff Qualifications:

- A psychiatrist licensed in Vermont.
- A psychologist licensed in Vermont.
- A professional nurse holding a M.S. in Psychiatric/Mental Health Nursing from a university with an accredited nursing program, licensed in Vermont.
- A social worker holding a clinical license in Vermont.
- A mental health counselor licensed in Vermont.
- Persons with a minimum of a Master's level degree in a human services field approved by the clinical or medical and executive director as qualified to provide clinical assessment services. A current list of all individuals so approved, signed by the clinical director and the executive director, must be kept on file at the center.

Staff qualifications for clinical assessment also apply to contracted employees.

Documentation Requirements:

Documentation in the case record must contain the nine following current (done within the past six months), discreet, labeled elements:

- History of the presenting complaint or issue;
- Psychosocial history;
- Medical history;
- Mental status;
- Individual strengths that will be contributory to treatment outcomes;
- Individual needs or deficits voiced or identified as a result of assessment;
- Diagnosis or impression;
- Clinical formulation or interpretive summary; and
- Treatment recommendations.

Rate:

To be costed and periodically published in memos.

Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility
53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

For Routine Care: (excludes Location 23*)

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: E01

Procedure Code for Medicaid Billing: 90801 + Modifier **HE** + Mental Health Clinic Adult Provider Number

For Emergency Care:

Cost Center: 57 – Crisis Services 69 – Elder Care

MCIS Service Code: G01

Procedure Code for Medicaid Billing: H0031 + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

A single clinician need not necessarily be the collector of all the data, but documentation should reference and assimilate all pertinent data of other qualified clinicians. If referenced data (i.e. psychosocial history, medical history etc.) is used, there must be an update from the date of the most recent referenced material (if older than six months).

Only time spent by a qualified clinician collecting assessment information may be reimbursed as clinical assessment. Information obtained by non-qualified staff in face-to-face contact for a clinical assessment or re-assessment and signed off by a qualified clinician may not be reimbursed as clinical assessment service. Assessment information obtained in this manner may be reimbursed separately as community support service.

Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other service (e.g. billing community support services rather than Diagnosis and Evaluation). (see Field Questions and Clarifications Section VIII)

A clinical assessment or reassessment which extends over several services should be entered into the individual's record as one cumulative assessment with the dates and lengths of service outlined at the beginning of the assessment.

The administration and interpretation of a diagnostic instrument is reimbursable, as long as the nine elements of clinical assessment are present and referenced. Testing reports should have a narrative as well as test results (scores).

Assessment "write-up time" is not service time that is reimbursable. This time is indirect service time and already allocated in administrative costs.

Administratively required assessments (e.g. assessment ordered by a judge or social agency) that do not meet clinical assessment and service prescription requirements are not reimbursable.

4. Individual Therapy (PSYCHOTHERAPY)

Definition:

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of two (2) hours per day, and no more than seven (7) hours per week, per individual. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for individual therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;
- If indicated, the involvement of family and/or significant others in treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed periodically and published in memos.

Location codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room
32* = Nursing Facility 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

For Routine Care: (excludes Location 23*)

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: E02

Procedure Code for Medicaid Billing: H2019 + Modifier **HE** + Mental Health Clinic Adult Provider Number

For Emergency Care:

Cost Center: 57 – Crisis Services 69 – Elder Care

MCIS Service Code: G01

Procedure Code for Medicaid Billing: H2019 + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

Individual therapy is face-to-face. Individual therapy provided in any other medium is not reimbursable.

Only one charge may be made for any service regardless of the number of therapists present.

Individual therapy with a spouse of a Medicaid eligible individual, who is ineligible for Title XIX, cannot be reimbursed by Medicaid.

An individual therapy session lasting 14 minutes or less (1 unit) will not be reimbursed.

Each session requires a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

5. Family Therapy (PSYCHOTHERAPY)

Definition:

Family Therapy is an intervention by a therapist with an individual and his/her family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of two (2) hours per day, and no more than seven (7) hours per week, per individual. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for family therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed periodically and posted in memos.

Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 32* = Nursing Facility 53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

55 – Clinical Interventions 69 – Elder Care

MCIS Service Code:

E03

Procedure Code for Medicaid Billing:

H2019 + Modifier **HE** + Modifier **HR** (when client is present) + Mental Health Clinic Adult Provider Number

H2019 + Modifier **HE** + Modifier **HS** (when client is not present) + Mental Health Clinic Adult Provider Number.

Clarifications:

A family therapy session is face-to-face. Family therapy provided in any other medium is not reimbursable.

Only one charge may be made for any service regardless of the number of therapists present.

Couples therapy sessions will be reimbursed as family therapy. Bill for only one family member.

A family therapy session lasting 14 minutes or less (1 unit) will not be reimbursed.

Each session needs a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

6. Group Therapy (GROUP THERAPY)

Definition:

Group Therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy may focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couple's therapy.

Limits:

Reimbursement is limited to a minimum of one (1) hour (4 units) and a maximum of two (2) hours per day, and no more than ten (10) hours per week, per individual**.** There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for group therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual (the individual response to the group dynamic in the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed and periodically published in memos.

Location Codes:

03 = School 12 = Home 32* = Nursing Facility 53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

55 – Clinical Interventions 69 – Elder Care

MCIS Service Code:

E04

Procedure Code for Medicaid Billing:

H2032 + Modifier **HE** + Modifier **HQ** + Mental Health Clinic Adult Provider Number

Clarifications:

Group Therapy sessions may not exceed a 1-to-10 clinician ratio or exceed a maximum of (15) individuals.

Group Therapy for less than one hour (60 minutes) is not reimbursable.

If two or more clinicians lead a group, only one can bill.

7. Medication Evaluation, Management and Consultation Services (CHEMOTHERAPY)

Definition:

Medication Management and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's health care.

Medication evaluation, management, and consultation services are face-to-face services.

Limits:

Reimbursement is limited to one (1) service per day, and no more than four (4) services per calendar week. A service must be at least fifteen (15) minutes (2 units) in duration. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

A physician, registered nurse, advanced practice nurse, or physician's assistant licensed in Vermont and operating within the scope of their respective professions may provide medication evaluation, management, and consultation services if the individual plan of care specifies this service plan. (**Note:** See Field Questions and Clarifications for resident physicians)

Documentation Requirements:

The administration of medication per se is not reimbursable as medication evaluation, management, and consultation services. There must be a face-to-face interaction with the individual which includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication. Furthermore, the reaction of the individual to the medication is not only in terms of the physical reaction (side effects) but most importantly the mental status change at which the medication is aimed and requires both pharmacological and mental health psychiatric skills. It should also include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

Rate:

To be costed periodically and published in memos.

Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility
53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

For Routine Services: (excludes Location 23*)

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code : E05

Procedure Code for Medicaid Billing: (Physician only) 90862 + Modifier **HE** + Modifier **UD** + Mental Health Clinic Adult Provider Number

Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HE** + Mental Health Clinic Adult Provider Number

For Group Services: (excludes Location 23*)

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: E05

Procedure Code for Medicaid Billing: (Physician Only) 90862 + Modifier **HE** + Modifier **HQ** + Modifier **UD** + Mental Health Clinic Adult Provider Number

Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HE** + Modifier **HQ** + Mental Health Clinic Adult Provider Number

For Emergency Services:

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: G01

Procedure Code for Medicaid Billing: (Physician Only) H2010 + Modifier **ET** + Modifier **UD** + Mental Health Clinic Adult Provider Number

Procedure Code for Medicaid Billing: (all other medical personnel) H2010 + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual.

8. Medication/Psychotherapy Service

Definition:

Medication/Psychotherapy Services is a planned treatment intervention maximizing two service modalities: individual psychotherapy and medication management. The service combines the formal individual mental health relationship and its therapeutic interactions to alleviate distress with the qualified healthcare professional's capacity to evaluate and manage medications as part of the course of overall treatment.

Medication evaluation, management, and consultation services are face-to-face services.

Limits:

Reimbursement is limited to one (1) service per day, and no more than three (3) hours per calendar week. A service must be at least 30 minutes in duration. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

A physician or an authorized APRN licensed in Vermont may provide medication/psychotherapy services if the individual plan of care specifies this service plan.

Documentation Requirements:

There must be a face-to-face interaction with the individual that in addition to the requirements of Individual Psychotherapy documentation includes evaluation of ongoing psychiatric symptoms, efficacy and management of medication being prescribed or continued, and/or the monitoring of the individual's response to the medication. Individual response should be assessed for physical reaction (side effects) and mental status change. Documentation may include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

Rate:

To be costed periodically and published in memos.

Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility
53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

For Routine Service: (excludes Location 23*)

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: E05

Procedure Code for Medicaid Billing: (Physician only)	90805 (30 minutes) + Modifier **HE**+ Modifier **UD** + Mental Health Clinic Adult Provider Number
	90807 (60 minutes) + Modifier **HE**+ Modifier **UD** + Mental Health Clinic Adult Provider Number
	90809 (90 minutes) + Modifier **HE**+ Modifier **UD** + Mental Health Clinic Adult Provider Number
Procedure Code for Medicaid Billing: (all other medical personnel)	90805 (30 minutes) + Modifier **HE**+ Mental Health Clinic Adult Provider Number
	90807 (60 minutes) + Modifier **HE**+ Mental Health Clinic Adult Provider Number
	90809 (90 minutes) + Modifier **HE**+ Mental Health Clinic Adult Provider Number

For Emergency Service:

Cost Center: 55 – Clinical Interventions 69 – Elder Care

MCIS Service Code: G01

Procedure Code for Medicaid Billing: (Physician only)	90805 (30 minutes) + Modifier **ET** + Modifier **UD** + Mental Health Clinic Adult Provider Number
	90807 (60 minutes) + Modifier **ET** + Modifier **UD** + Mental Health Clinic Adult Provider Number
	90809 (90 minutes) + Modifier **ET** + Modifier **UD** + Mental Health Clinic Adult Provider Number
Procedure Code for Medicaid Billing: (all other medical personnel)	90805 (30 minutes) + Modifier **ET** + Mental Health Clinic Adult Provider Number
	90807 (60 minutes) + Modifier **ET** + Mental Health Clinic Adult Provider Number
	90809 (90 minutes) + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

Medication/Psychotherapy services must be identified in the individual service plan.

Medical personnel may bill emergency medication/psychotherapy services only in those emergency situations where a pre-existing treatment relationship already exists between that clinician and the client.

9. Emergency Care and Assessment Services

Definition:

Emergency Care and Assessment Services are acute, time-limited, intensive supports provided to individuals, their families, or their immediate support system who are currently experiencing a psychological, behavioral, or emotional crisis. Services are initiated on behalf of a person or provided to a person/s experiencing an acute mental health crisis as evidenced by: (1) a sudden change in behavior with negative consequences for well-being; (2) a loss of effective coping mechanisms; or, (3) presenting danger to self or others. Services include triage, early intervention, information gathering, consultation, and planning for crisis stabilization. Assessment includes acute outreach, crisis evaluation, treatment and direct clinical interventions, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission. These services are available 24 hours a day, 7 days a week.

Emergency Care and Assessment Services may be face-to-face or provided by telephone.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of $500.00 per client per day and no more than 35 hours per week per individual.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency or provided by staff who, based on his/her education, training, or experience and under the supervision of an enrolled physician or Medical Director affiliated with the Designated Agency, is authorized as competent to provide the service.

Documentation Requirements:

A. Telephone Intervention guidelines:

One progress note per day is required documenting the emergency care and assessment services provided to an individual by phone. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- The clinician's impressions/assessment of the issues/situation;
- Disposition or plan resulting from the crisis intervention

If telephone Emergency Care and Assessment Services are documented in a log and are provided by the same individual, that crisis staff member would need to sign the page only once. However, if other crisis staff members enter notes periodically in the log, their signatures must accompany their individual notes.

B. Face-to-Face Intervention guidelines:

One progress note per face-to-face contact is required documenting the emergency care and assessment services provided to an individual. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;

- Collateral contact information as solicited or available;
- Observations made by the clinician;
- The clinician's assessment of the issues/situation including mental status and lethality/risk potential;
- Disposition or plan resulting from the crisis intervention;
- Psychiatric consultation, as clinically indicated.

It is acceptable to document telephone and face-to-face Emergency Care and Assessment Services in a log book only if all documentation requirements are present.

Rate:

To be costed periodically and published in memos.

Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility
53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

57 – Crisis Services 69 – Elder Care

MCIS Service Code:

G01

Procedure Code for Billing Medicaid:

H2011 + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

A face-to-face or telephone emergency care and assessment service lasting less than 15 minutes cannot be reimbursed.

Emergency care and assessment services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan.

No matter how many clinicians are involved at the same time with an individual or significant others during a crisis, only one clinician's time will be reimbursed. If two separate services are provided that require unique qualifications (e.g. medication management that can only be provided by medical personnel and emergency care services that is provided by a different qualifying clinician), each clinician may bill only for the time spent in their specific service.

If the majority of the emergency care and assessment services were provided in the office, the location code of the mental health center should be used.

During an emergency care and assessment service, it would be legitimate to include time spent transporting an individual. However, a clinician's travel time to or from the emergency scene is not reimbursable.

10. Crisis Stabilization and Support Services (Emergency Community Support)

Definition:

Crisis Stabilization, Support, and Referral Services are focused and ongoing support services provided to individuals, their families, or their immediate support system that may be time-limited, but necessary to maintain stability or avert destabilization of an expected psychological, behavioral, or emotional crisis. Services are provided to persons experiencing mental health crisis as evidenced by: (1) a progressing change in behavior with negative consequences for well-being; (2) declining or loss of usual coping mechanisms; or, (3) increasing risk of danger to self or others. Crisis stabilization services are face-to-face services in an environment other than a person's home. Support and referral includes triaging aftercare needs, supportive counseling, skills training, symptom management, medication monitoring, crisis planning, and assistance with referrals from crisis stabilization in a person's home or by phone. These services are available 24 hours a day, 7 days a week.

Limits:

DDMHS Medicaid reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of eight (8) units per eight hour period. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency or provided by staff who, based on his/her education, training, or experience and under the supervision of an enrolled physician or Medical Director affiliated with the Designated Agency, is authorized as competent to provide the service.

Documentation Requirements:

Crisis stabilization and support service needs must be documented upon admission, per shift and/or per 8 hour period of crisis stabilization, and upon discharge for all emergency community support services. Other Medicaid services provided during the crisis stabilization period must follow the documentation requirements for that service. Crisis stabilization and support services should include, in summary form:

Admission Documentation

- Precipitant crisis or behavioral/psychiatric decompensation (e.g. observation of behavior supporting crisis stabilization);
- Assessment of treatment needs or anticipated benefits of proactive clinical intervention;
- Plan for treatment (e.g. issues to be addressed or discussed);
- Physician consultation and agreement with treatment plan.

Per shift and/or 8 hour period of ongoing crisis stabilization

- Observations made of the individual (e.g. behavioral or psychiatric indicators for ongoing crisis stabilization);
- Interventions and client response;
- The clinician's assessment of the issues/situation/risks;
- Ongoing plan for crisis stabilization.

Discharge Summary

- Observations of individual's current behavior and presentation;
- Issues addressed or discussed or skills developed in the course of service;
- The clinician's assessment of the client response to crisis stabilization;
- Follow-up plan (e.g. appointments, supports, medication change, etc.)

It is acceptable to document crisis stabilization and support services in a log. If all crisis stabilization and support services documented in a log are provided by the same individual, that staff member would need to sign the page only once. However, if other staff members enter notes periodically in the log, they would need to sign their own individual notes. The log sheet should be placed in the clinical record for purposes of audit.

Rate:

To be costed periodically and published in memos.

Location Codes:

12 = Home 53 = DA/SSA Site 99 = Community

Cost Center:

58 – Emergency/Crisis Beds 69 – Elder Care

MCIS Service Code:

G01 if services are provided in the person's primary living situation or by phone (support/referral)

G02 if services are provided in another crisis stabilization facility (crisis stabilization)

Procedure Code for Billing Medicaid:

H2017 + Modifier **ET** + Mental Health Clinic Adult Provider Number

Clarifications:

If crisis stabilization and support service admission and discharge occur within the course of an 8 hour period, documentation may abbreviate admission, shift, and discharge information into a summary overview note to reflect the brief course of care.

Crisis stabilization services billed per 8 hour period or per day may not bill for other mental health services provided during the time period billed to crisis stabilization services.

Crisis stabilization and support services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan. Crisis stabilization services documentation should reflect early on that a review with a physician has occurred and a determination made that crisis stabilization services are required.

11. Specialized Community Supports (SPECIALIZED REHABILITATION SERVICES)

Definition:

Specialized Community Supports are individualized and goal oriented services to assist individuals who are not identified as severely and persistently mentally ill, but who have complicated diagnostic and psychosocial needs and diminished function to access community supports and develop social skills necessary to improve overall function and promote community connectedness. These supports may include, support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.

Accessing and utilizing community services and activities may include the development of those skills that enable an individual to seek out, clarify, and maintain resources, services, and supports for independent living in the community, including communication and socialization skills and techniques.

Advocacy and collateral contacts may include collateral contacts with family (husband, wife, parents, children), area resources and services, or significant others (roommates, friends, partners, etc.) to insure an effective treatment environment for the individual. The Medicaid individual must be central to such services. Collateral contacts can be provided either face-to-face or on the phone.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations. This activity can be provided either face-to-face or on the phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budgeting, meal planning, household maintenance, and community mobility skills.

Rarely, specialized group community support may be an appropriate treatment modality. This intervention strategy should clearly align individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) or a maximum of $500.00 per client per day.

For specialized group community support, no less than a one staff member to four (4) individual ratio can be present. Reimbursement for specialized group community support is limited to two (2) hours per day (8 units) and no more than ten (10) sessions per week per individual.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

Specialized community supports may be documented by each service provided; or with one monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for individual or group treatment modality should identify:

- Service modality (individual community support or group community support)
- Summarize each service by describing the discussion/training/skill building provided and its purpose. Identifying treatment modality (e.g. specialized community support is inadequate to describe the activity)
- Describe individual's response or clinician's observations.
- Describe overall outcome/results/progress in relation to the individual service plan.

Monthly summary documentation (in addition to billed services print-out) should identify:

- Summary of major content or intervention themes consistent with treatment goals;
- Observations made of the individual or responses to interventions;
- Assessment of progress toward treatment goal;
- Ongoing needs for continued intervention and plan.

Rate:

To be costed periodically and published in memos.

Location Codes:

(B01 Cost Centers 67, 69) – To an Individual

03 = School 12 = Home 21* = Inpatient Hospital 32* = Nursing Facility 53 = DA/SSA Site
99 = Community

(B02 Cost Centers 67, 69) – To a Group

03 = School 12 = Home 32* = Nursing Facility 53= DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

67 – Community Supports and Service Planning 69 – Elder Care

MCIS Service Code:

B01 (Individual)
B02 (Group)

Procedure Code for Medicaid Billing:

Individual Service H2017 + Modifier **HE** + Mental Health Clinic Adult Provider Number

Group Service H2014 + Modifier **HE** + Modifier **HQ** + Mental Health Clinic Adult Provider Number

Clarifications:

Specialized community supports may be provided simultaneously with other services, but only one service can be billed (e.g. one worker is providing crisis stabilization and support services and another staff member is providing specialized community support; both services cannot be billed; one or the other may be billed).

Only supportive counseling and advocacy and collateral contact can be done in a nursing facility. Daily living and social skills interventions are provided through the nursing facility Medicaid per diem.

Vocational and educational service activities cannot be billed as specialized community supports.

Transportation costs are included in the specialized community support service rate. For example, if a staff member transports an individual to a community service to assist them in overcoming any barriers in accessing that service, transportation cannot be billed in addition to community supports.

12. Partial Hospitalization (DAY HOSPITAL)

Definition:

Partial Hospitalization is an intensive, highly structured (5-16 hours/day) time-limited (maximum 21 days) therapeutic treatment environment provided as an alternative to psychiatric inpatient care, step-down from psychiatric hospitalization, or as a support to psychiatric destabilization. Partial hospitalization services are provided to individuals who would otherwise meet inpatient criteria, and medical personnel (nurse, physician) are accessible to provide services during the hours of operation. At least two treatment services must be provided and documented each day. Treatment services include assessment; service planning and coordination; community support; individual, group and/or family therapy; medication management and psycho-educational skill development.

Limits:

Reimbursement is limited to one (1) session per day, with at least three sessions per week, but no more than seven (7) sessions per week. A session must be at least five (5) hours in duration. No other service except emergency care and assessment service will be reimbursed for an individual on a day that partial hospitalization services have been provided. There is a daily limit of $500.00 for all services per client. **Prior authorization must be obtained from DDMHS.**

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician directly alleviated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training. or experience is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a daily progress note for partial hospitalization must include in summary form the relationship of the services to the treatment regimen outlined in the individual service plan updating the individual's progress:

- Issues discussed or addressed;
- Observations made of the individual;
- The clinician's assessment of the issues;
- Progress toward treatment plan goals;
- Ongoing indications/rationale for partial hospitalization;
- Description of change in approach, if necessary.

Rate:

To be costed periodically and published in memos.

Location Codes:

53 = DA/SSA Site

Cost Center:

55 – Clinical Interventions 69 - Elder

MCIS Service Code :

K 01

Procedure Code for Medicaid Billing:

H0035 + Modifier **HE** + Mental Health Clinic Adult Provider Number

NOTE: DDMHS prior authorization required

Clarifications:

Attendance sheets which list the hours of service are acceptable, provided they meet all the requirements listed for time sheets, as a record of the time spent receiving partial hospitalization services.

For individuals receiving partial hospitalization service, "indirect" treatment services (e.g. some service planning and coordination activities) are acceptable activities of a partial hospitalization program.

A partial hospitalization program may not be set up in a group home.

13. Transportation

Definition:

Transportation services are only for the necessary transportation of individuals, covered by Medicaid, to and from an agency facility in order to receive Medicaid reimbursable services. "Necessary" means that the individual has no reasonable alternative transportation available and, without such transportation, would not be able to receive these Medicaid services.

Limits:

Reimbursement is limited to two (2) one-way trips per day, when at least one Medicaid reimbursable service is provided by the designated agency on the same day. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

Any individual or agency hired or contracted with to provide transportation services, with the approval of the executive director can provide transportation services.

Documentation Requirements:

A driver's log signed by the driver or any other procedure approved by the Department of Developmental and Mental Health Services will suffice.

Documentation that the individual received a Medicaid reimbursable service that day must also exist.

Rate:

Transportation rates will be calculated on a per center basis.

Cost Center:

13

MCIS Service Code:

I 01

Procedure Code for Medicaid Billing:

T2003 + Modifier **HE** + Mental Health Clinic Adult Provider Number

Clarifications:

Field trips or other transportation provided as part of a medical service are not eligible for reimbursement.

Transportation for a Developmental Services client would be coded using a HW Modifier.

SECTION II

CHILDREN'S

MEDICAID FEE-FOR-SERVICE

TRADITIONAL MEDICAID RECIPIENTS

CLINICAL AND SUPPORT SERVICES

CHILDREN'S CLINICAL AND SUPPORT SERVICES

1. Eligible Providers

An entity is considered enrolled for participation in the Medicaid program when it is a designated agency and has a signed contract with DDMHS for the services identified in this manual or is otherwise authorized by the Commissioner of the Department of Developmental and Mental Health Services. If the Designated Agency subcontracts services to be performed under this signed contract, it is the responsibility of the Designated Agency to ensure that the subcontractor adheres to the requirements set forth in this manual. The subcontractor is then able to perform these services on behalf of the Designated Agency. An entity may also be designated and enrolled for participation in the Medicaid program if otherwise authorized by the Commissioner of the Department of Developmental and Mental Health Services.

❖ **Eligibility for Participation:**

Medicaid payment for covered services is limited to Commissioner designated agencies (community mental health centers) and other Commissioner designated entities that are established for the purpose of providing community-based mental health care. In order for a Commissioner designated agency or entity to be eligible for participation under the Medicaid State Plan, it must agree to comply with appropriate federal regulations and to perform and bill for services, maintain records, and adhere to the supervision, regulations, standards, procedures, and this manual's requirements of the Commissioner of Developmental and Mental Health Services pursuant to 18 VSA, Chapter 177, Section 7401(2), (4), and (15); and 18 VSA, Chapter 207, Sections 8907 through 8913.

- The service must be either provided directly by a Vermont Medicaid enrolled physician affiliated with the designated agency, or prescribed by a physician or authorized advanced practice nurse practitioner directly affiliated with the designated agency and provided by a staff member who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director of the designated agency as competent to provide the service.

- The service must have been delivered by a sub-contractor, the Designated Agency itself, or an entity otherwise authorized by the Commissioner of Developmental and Mental Health Services and provided by a qualified staff member who, based on his/her education, training, or experience is authorized by the prescribing physician or Medical Director of the designated agency as competent to provide the service.

❖ **Commissioner Designated Agency/Entities:** Billing is allowed only for services provided by:

- Qualified staff who are employed by a designated agency/entity;

- Students/interns, provided that the student/intern is supervised by a qualified staff of the designated agency/entity, is subject to all designated agency/entity policies and procedures, and that the designated agency/entity and the supervising physician assume responsibility for the work performed.

❖ **Designated Agency/Entity Sub-Contractors:** Entities or individuals working under sub-contract for a designated agency/entity acts as an employee of the designated agency/entity for purposes of billing Title XIX services. Sub-contracts must be available for review by Title XIX auditors. Sub-contracts require provisions showing:

- With whom the sub-contract is made, stating specific individuals and their credentials;

- What specific Title XIX services the sub-contractor will provide under the sub-contract;

- The staff member responsible for monitoring billing practices of the sub-contractor;

- The staff member responsible for providing supervision over the clinical practices of the sub-contractor (with the exception of contract physicians).

2. Service Prescription, Documentation and General Clarifications

Every Medicaid eligible individual must have an Individual Plan of Care (IPC) based upon assessed treatment needs. When some or all members of the family are Medicaid eligible, a family IPC may still be written provided each individual's goals, objectives, and interventions are clearly stated. In situations where only the child is the Medicaid eligible service recipient and the family is the primary focus for treatment, a Family IPC must be written (see Field Questions and Clarifications Section VIII). Part of the plan must focus on and specify treatment and progress for the eligible child. Additional goals, objectives, and interventions must identify the family treatment.

Individual Plan of Care

The IPC is directly related to assessments and must encompass, at a minimum, the services prescribed and provided by the designated agency to the individual. It must contain the following components:

- **Goals:** A statement of the mutually desired overall, long range results of interventions expressed in the individual's words as much as possible.

- **Objectives:** A statement of the specific individual skills and/or community resources that need to be changed or modified to achieve each goal. Objectives are to be stated in observable and measurable terms.

- **Interventions:** A description of the interventions to be used to achieve each objective including:
  - The staff position or service component responsible;
  - The intervention activity (Medicaid modality);
  - The frequency of the activity (measurable). PRN or "as needed" frequency should be reserved for emergent or episodic service delivery. It is acceptable to identify a range of treatment frequency for planned services or interventions. Such treatment or service delivery changes may be substantiated in clinical notes, subsequent quarterly reviews, or IPC addendums.

- **Outcomes:** The anticipated outcome resulting from the treatment and/or services provided for the identified goal.

At a minimum, the plan must be signed by the primary clinician or case manager, the physician or authorized advanced practice nurse practitioner, and whenever possible, the individual. Any other team member providing treatment should be encouraged to review and sign the individual plan of care.

Prescription

- ❖ Prescription is a physician's authorization of treatment as indicated by the physician's signature on an Individual Plan of Care.

- ❖ Prescription is an authorized advanced practice registered nurse's (APRN) authorization of treatment as indicated by the APRN's signature on an Individual Plan of Care.

- ❖ Treatment and service modalities, with the exception of emergent treatment needs and services, must be prescribed in the Individual Plan of Care or subsequent addendums for the period in which the treatment and service modalities is provided to be eligible for reimbursement. Emergency treatment needs and services may be prescribed as PRN or "as needed" services, but do not need to be prescribed as planned services. IPCs should prescribe services that you intend to deliver (not every possible option). (see Field Questions and Clarifications Section VIII)

- ❖ For mental health services, "prescription of an individual plan of care" must be obtained prior to the fourth reimbursed service.

Prescription Review

Individual Plans of Care (IPC's) must be developed annually (total rewrite) with physician or authorized APRN signature and reviewed quarterly unless the individual's condition and/or treatment needs change; necessitating the addition, deletion, or modification of prescribed interventions. An addendum is required if services have a sustained pattern of change. Addendums, representing a prescriptive change, require physician or authorized APRN signature. At a minimum, the quarterly review (every 90 days from a complete, annual IPC) and routine prescription must be indicated by the physician's or APRN's signature. IPC's should be completed prior to the fourth reimbursed service (Note: emergency care services are exempt from this requirement).

IPC Clarifications

Checklists of services or treatment modalities by themselves do not constitute individual plans of care. Additional notes are required to explain the information that has been "checked off".

The individual should be directly involved in establishing his/her IPC to the extent possible. It is not required that the individual be present when the IPC is updated.

If an individual has not had services for six months or the individual plan of care or quarterly review recommends the IPC be closed, then the case must be considered closed. Individual's requesting services after six months from the date of their last service should be considered new to services and must have a new plan of care prescribed. A new Diagnostic Assessment should be considered following a period of non-service or significant change in clinical presentation. In such cases, an addendum or update to information is acceptable if a comprehensive assessment was completed within the previous six months.

General Record Keeping Requirements

Documentation of services provided must be legible, of sufficient clarity, and sufficient clinical content (minimum required content is specified for each service) to ensure eligibility for payment. Auditors must be able to read the service documentation.

All clinical and support notes must include:

- Identification of the individual served;
- The date the service was rendered;
- The specific title or code of the service rendered;
- Location in which the service occurred;
- The amount of time it took to deliver the service;
- Reference to the treatment goal for the service;
- Summary of the service rendered with appropriate clinical content (refer to specific service documentation requirements);
- Who rendered the service (signature). (See Clarifications this section)
- Title and qualifications of the service provider. If not required by the agency, qualifications, degrees and titles must be on file at the designated agency and provided during audit.

If co-therapists are involved in treatment, either may sign the progress note.

Each reimbursed service must be documented in the individual's case record. This documentation may be in another provider's files but must be available to Title XIX auditors and identified with the individual's name and/or record number.

The use of white-out in the clinical record is prohibited. The use of cross-outs to alter information that has been entered into the clinical record is the only acceptable method of changing information. Information to be altered should have a single line through the information and must be accompanied by the initials of the staff making the alterations.

Checklists by themselves are not acceptable as clinical or support notes. Additional narrative is required to explain the information that has been "checked off".

A time sheet serves as the source document for Medicaid billing. Time sheet information must match billing and the individual's clinical record data. The time sheet must include:

- Identification of the individual
- Staff member identification
- Signature of staff member
- Program and cost center
- Service (Medicaid modality)
- Duration
- Date
- Number of individuals receiving service present
- Location
- If other staff are present (time sheets may need to be reviewed during an audit)

Clarifications:

Typically, who rendered the service refers to the written signature of the individual treater. A printed signature for verification purposes is inadequate. Agencies, requesting and demonstrating appropriate safeguards for use of computer generated signatures, may be authorized to use electronic signature technology if policies and procedures for the agency are submitted and approved by DDMHS.

3. Clinical Assessment (DIAGNOSIS AND EVALUATION)

Definition:

Clinical Assessment services evaluate across environments individual and family strengths, needs, existence and severity of disability(ies) and functioning. A clinical assessment is a service related to identifying the extent of an individual's condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the individual's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory, and orientation; an evaluation of the individual's social situation relating to family background, family interaction and current living situation; an evaluation of the individual's social performance, community living skills, self-care skills and prevocational skills; an evaluation of the support system's and community's strengths and availability to the individual and family; and/or an evaluation of strategies, goals and objectives included in the development of a service plan.

Clinical Assessment or reassessment must be a face-to-face contact.

Limits:

Clinical Assessment is a "pay as billed" one unit service up to the allowable limits of four units of service annually. Each clinical assessment is considered one unit in its entirety. Reimbursement is limited to a minimum of one-half (1/2) hour sessions. The sum of time spent on the clinical assessment is billed as one unit and the re-imbursement rate is calculated based on the fee schedule for 15 minute increments. There is no set dollar amount for a clinical assessment, the service will be "paid as billed" according to the time spent in 15 minute intervals. The Clinical Assessment limits may be adjusted based on a case-by-case review by the Department of Developmental and Mental Health Services of supporting information from the Designated Agency. Prior written authorization is required for any extended services.

Staff Qualifications:

- A psychiatrist licensed in Vermont.
- A psychologist licensed in Vermont.
- A professional nurse holding a M.S. in Psychiatric/Mental Health Nursing from a university with an accredited nursing program, licensed in Vermont.
- A social worker holding a clinical license in Vermont.
- A mental health counselor licensed in Vermont.
- Persons with a minimum of a Master's level degree in a human services field approved by the clinical or medical and executive director as qualified to provide clinical assessment services. A current list of all individuals so approved, signed by the clinical director and the executive director, must be kept on file at the center.

Staff qualifications for clinical assessment also apply to contracted employees.

Documentation Requirements:

Documentation in the case record must contain the nine following current (done within the past six months), discreet, labeled elements:

- History of the presenting complaint or issue;
- Psychosocial history;
- Medical history;
- Mental status;
- Individual strengths that will be contributory to treatment outcomes;
- Individual needs or deficits voiced or identified as a result of assessment;
- Diagnosis or impression;
- Clinical formulation or interpretive summary; and
- Treatment recommendations.

Rate:

To be costed and periodically published in memos.

Location Codes:

03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility]
53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

55 – Clinical 19 – Success Beyond Six 22-ISB 23 – Access 26 – CUPS 71 - JOBS

Cost Center: 55 – Clinical 22-ISB 23 – Access 26 – CUPS 71 - JOBS

MCIS Service Code: E01

Procedure Code for Medicaid Billing: 90801 + Modifier **HE** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six

MCIS Service Code: E01

Procedure Code for Medicaid Billing: 90801 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

A single clinician need not necessarily be the collector of all the data, but documentation should reference and assimilate all pertinent data of other qualified clinicians. If referenced data (i.e. psychosocial history, medical history etc.) is used, there must be an update from the date of the most recent referenced material (if older than six months).

Only time spent by a qualified clinician collecting assessment information may be reimbursed as clinical assessment. Information obtained by non-qualified staff in face-to-face contact for a clinical assessment or re-assessment and signed off by a qualified clinician may not be reimbursed as clinical assessment service. Assessment information obtained in this manner may be reimbursed separately as community support service.

Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other service (e.g. billing community support services rather than Diagnosis and Evaluation).

A clinical assessment or reassessment which extends over several services should be entered into the individual's record as one cumulative assessment with the dates and lengths of service outlined at the beginning of the assessment.

The administration and interpretation of a diagnostic instrument is reimbursable, as long as the nine elements of clinical assessment are present and referenced. Testing reports should have a narrative as well as test results (scores).

Assessment "write-up time" is not service time that is reimbursable. This time is indirect service time and already allocated in administrative costs.

Administratively required assessments (e.g. assessment ordered by a judge or social agency) that do not meet clinical assessment and service prescription requirements are not reimbursable.

4. Individual Therapy (PSYCHOTHERAPY)

Definition:

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of two (2) hours per day, and no more than seven (7) hours per week, per individual. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont enrolled physician directly affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for individual therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual (the individual's response to the treatment session) or any significant factors affecting treatment;
- If indicated, the involvement of family and/or significant others in treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed periodically and published in memos.

Location codes:

03 = School 12 = Home [Rare- 21* = Inpatient Hospital 23* = Emergency Room
32* = Nursing Facility] 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center:

55 – Clinical 19 – Success Beyond Six 22 – ISB 23 – Access 26 – CUPS 71 – JOBS

Cost Center: 55 – Clinical 22-ISB 23 – Access 26 – CUPS 71 – JOBS

MCIS Service Code: E02

Procedure Code for Medicaid Billing: H2019 + Modifier **HE** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six

MCIS Service Code: E02

Procedure Code for Medicaid Billing: H2019 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

Individual therapy is face-to-face. Individual therapy provided in any other medium is not reimbursable.

Only one charge may be made for any service regardless of the number of therapists present.

Individual therapy with a spouse of a Medicaid eligible individual, who is ineligible for Title XIX, cannot be reimbursed by Medicaid.

An individual therapy session lasting 14 minutes or less (1 unit) will not be reimbursed.

Each session requires a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

5. Family Therapy (PSYCHOTHERAPY)

Definition:

Family Therapy is an intervention by a therapist with an individual and his/her family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of two (2) hours per day, and no more than seven (7) hours per week, per individual. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for family therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual and family (the individual or family system response to the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed periodically and posted in memos.

Location Codes:

03 = School 12 = Home [Rare -21* = Inpatient Hospital 32* = Nursing Facility] 53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 55 – Clinical 22-ISB 23 – Access 26 - CUPS
MCIS Service Code: E03
Procedure Code for Medicaid Billing: H2019 + Modifier **HE** + Modifier **HR** + and (Billed under the MH Clinic Child Provider number)when client **is present.**

H2019 + Modifier **HE** + Modifier **HS** + and (Billed under the MH Clinic Child Provider number)when client is **not present.**

Cost Center: 19 – Success Beyond Six
MCIS Service Code: E03
Procedure Code for Medicaid Billing: H2019 + Modifier **HK** + Modifier **HR** and (Billed under the MH Clinic Success Beyond Six Provider number) when client **is present**

H2019 + Modifier **HK** + Modifier **HS** and (Billed under the MH Clinic Success Beyond Six Provider number) when client is **not present.**

Clarifications:

A family therapy session is face-to-face. Family therapy provided in any other medium is not reimbursable.

Only one charge may be made for any service regardless of the number of therapists present.

Couples therapy sessions will be reimbursed as family therapy. Bill for only one family member.

A family therapy session lasting 14 minutes or less (1 unit) will not be reimbursed.

Each session needs a discreet note; for instance, documentation of two ½ hour sessions on the same day, but at different times requires two progress notes. The notes may be included on the same page if practical.

6. Group Therapy (GROUP THERAPY)

Definition:

Group Therapy is an intervention strategy that treats individuals simultaneously for social maladjustment issues or emotional and behavioral disorders by emphasizing interactions and mutuality within a group dynamic. Group therapy may focus on the individual's adaptive skills involving social interaction to facilitate emotional or psychological change and improved function to alleviate distress.

Group therapy also includes multiple families or multiple couple's therapy.

Limits:

Reimbursement is limited to a minimum of one (1) hour (4 units) and a maximum of two (2) hours per day, and no more than ten (10) hours per week, per individual. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

The clinical content of a progress note for group therapy must include the relationship of the services in the treatment regimen with the goal outlined in the Individual Plan of Care and in summary form document:

- Current issues discussed or addressed;
- Observations made of the individual (the individual response to the group dynamic in the treatment session) or any significant factors affecting treatment;
- The clinician's assessment of the issues;
- Movement or progress toward the treatment goal (with any description of change in approach, if necessary); and
- Plan for ongoing treatment or follow-up.

Rate:

To be costed and periodically published in memos.

Location Codes:

03 = School 12 = Home [Rare - 32* = Nursing Facility]53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 55 – Clinical 22-ISB 23 – Access 26 - CUPS
MCIS Service Code: E04
Procedure Code for Medicaid Billing: H2032 + Modifier **HE** + Modifier **HQ** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six
MCIS Service Code: E04

Procedure Code for Medicaid Billing: H2032 + Modifier **HK** + Modifier **HQ** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

Group Therapy sessions may not exceed a 1-to-10 clinician ratio or exceed a maximum of (15) individuals.

Group Therapy for less than one hour (60 minutes) is not reimbursable.

If two or more clinicians lead a group, only one can bill.

7. Medication Evaluation, Management and Consultation Services (CHEMOTHERAPY)

Definition:

Medication Management and Consultation Services include evaluating the need for, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's health care.

Medication evaluation, management, and consultation services are face-to-face services.

Limits:

Reimbursement is limited to one (1) service per day, and no more than four (4) services per calendar week. A service must be at least fifteen (15) minutes (2 units) in duration. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

A physician, registered nurse, advanced practice nurse, or physician's assistant licensed in Vermont and operating within the scope of their respective professions may provide medication evaluation, management, and consultation services if the individual plan of care specifies this service plan. (**Note:** See Field Questions and Clarifications for resident physicians)

Documentation Requirements:

The administration of medication per se is not reimbursable as medication evaluation, management, and consultation services. There must be a face-to-face interaction with the individual which includes evaluation of the individual in terms of symptoms, diagnosis, and pharmacologic history; efficacy and management of the medication being prescribed or continued, and/or the monitoring of the individual's reaction (favorable or unfavorable) to the medication. Furthermore, the reaction of the individual to the medication is not only in terms of the physical reaction (side effects) but most importantly the mental status change at which the medication is aimed and requires both pharmacological and mental health psychiatric skills. It should also include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

Rate:

To be costed periodically and published in memos.

Location Codes:

03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room] 53 = DA/SSA Site
99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 55 – Clinical Interventions 22-ISB 23 – Access 26 - CUPS 71 - JOBS

MCIS Service Code: E05
Procedure Code for Medicaid Billing: (Physician only) 90862 + Modifier **HE** + Modifier **UD** and (Billed under the MH Clinic Child Provider number)

MCIS Service Code: E05
Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HE** + and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six
MCIS Service Code: E05
Procedure Code for Medicaid Billing: (Physician only) 90862 + Modifier **HK** + Modifier **UD** and (Billed under the MH Clinic Success Beyond Six Provider number)
Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

For Group Services:

Cost Center: 55 – Clinical Interventions 22-ISB 23 – Access 26 - CUPS
MCIS Service Code: E05
Procedure Code for Medicaid Billing: (Physician only) 90862 + Modifier **HE** + Modifier **HQ** + Modifier **UD** and (Billed under the MH Clinic Child Provider number)
MCIS Service Code: E05
Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HE** + Modifier **HQ** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six
MCIS Service Code: E05
Procedure Code for Medicaid Billing: (Physician only) 90862 + Modifier **HK** + Modifier **HQ** + Modifier **UD** and (Billed under the MH Clinic Success Beyond Six Provider number)
MCIS Service Code: E05
Procedure Code for Medicaid Billing: (all other medical personnel) 90862 + Modifier **HK** + Modifier **HQ** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

Medication evaluation, management, and consultation services may be done in a group setting if the client agrees to treatment in this forum. Separate notes must be written for each individual.

8. Medication/Psychotherapy Service

Definition:

Medication/Psychotherapy Services is a planned treatment intervention maximizing two service modalities: individual psychotherapy and medication management. The service combines the formal individual mental health relationship and its therapeutic interactions to alleviate distress with the qualified healthcare professional's capacity to evaluate and manage medications as part of the course of overall treatment.

Medication evaluation, management, and consultation services are face-to-face services.

Limits:

Reimbursement is limited to one (1) service per day, and no more than three (3) hours per calendar week. A service must be at least 30 minutes in duration. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

A physician or authorized APRN licensed in Vermont may provide medication/psychotherapy services if the individual plan of care specifies this service plan.

Documentation Requirements:

There must be a face-to-face interaction with the individual that in addition to the requirements of Individual Psychotherapy documentation, includes evaluation of ongoing psychiatric symptoms, efficacy and management of medication being prescribed or continued, and/or the monitoring of the individual's response to the medication. Individual response should be assessed for physical reaction (side effects) and mental status change. Documentation may include any discussion with the individual of other physician or laboratory reports as they pertain to his/her medical/mental health.

Rate:

To be costed periodically and published in memos.

Location Codes:

03 = School 12 = Home [Rare-23* = Emergency Room] 53 = DA/SSA Site 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 55 – Clinical Interventions 22-ISB 23 – Access 26 - CUPS

MCIS Service Code: E05

Procedure Code for Medicaid Billing:	90805 (30 minutes) + Modifier **HE** + Modifier **UD**
(Physician only)	90807 (60 minutes) + Modifier **HE**+ Modifier **UD**
	90809 (90 minutes) + Modifier **HE**+ Modifier **UD**
	and (Billed under the MH Clinic Child Provider number)

MCIS Service Code: E05

Procedure Code for Medicaid Billing:	90805 (30 minutes) + Modifier **HE**
(all other medical personnel)	90807 (60 minutes) + Modifier **HE**
	90809 (90 minutes) + Modifier **HE**
	and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six

MCIS Service Code: E05

Procedure Code for Medicaid Billing:	90805 (30 minutes) + Modifier **HK** + Modifier **UD**
(Physician only)	90807 (60 minutes) + Modifier **HK** + Modifier **UD**
	90809 (90 minutes) + Modifier **HK** + Modifier **UD**
	and (Billed under the MH Clinic Success Beyond Six Provider Number)

MCIS Service Code: E05

Procedure Code for Medicaid Billing:	90805 (30 minutes) + Modifier **HK**
(all other medical personnel)	90807 (60 minutes) + Modifier **HK**
	90809 (90 minutes) + Modifier **HK**
	and (Billed under the MH Clinic Success Beyond Six Provider Number)

Clarifications:

Medication/Psychotherapy services must be identified in the individual service plan.

Medical personnel may bill emergency medication/psychotherapy services only in those emergency situations where a pre-existing treatment relationship already exists between that clinician and the client.

9. Emergency Care and Assessment Services

Definition:

Emergency Care and Assessment Services are acute, time-limited, intensive supports provided to individuals, their families, or their immediate support system who are currently experiencing a psychological, behavioral, or emotional crisis. Services are initiated on behalf of a person or provided to a person/s experiencing an acute mental health crisis as evidenced by: (1) a sudden change in behavior with negative consequences for well-being; (2) a loss of effective coping mechanisms; or, (3) presenting danger to self or others. Services include triage, early intervention, information gathering, consultation, and planning for crisis stabilization. Assessment includes acute outreach, crisis evaluation, treatment and direct clinical interventions, and integration/discharge planning back to the person's home or alternative setting. Assessment may also include screening for inpatient psychiatric admission. These services are available 24 hours a day, 7 days a week.

Emergency Care and Assessment Services may be face-to-face or provided by telephone.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of $500.00 per client per day and no more than 35 hours per week per individual.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency or provided by staff who, based on his/her education, training, or experience and under the supervision of an enrolled physician or Medical Director affiliated with the Designated Agency, is authorized as competent to provide the service.

Documentation Requirements:

Telephone Intervention guidelines:

One progress note per day is required documenting the emergency care and assessment services provided to an individual by phone. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- The clinician's impressions/assessment of the issues/situation;
- Disposition or plan resulting from the crisis intervention

If telephone Emergency Care and Assessment Services are documented in a log and are provided by the same individual, that crisis staff member would need to sign the page only once. However, if other crisis staff members enter notes periodically in the log, their signatures must accompany their individual notes.

B. Face-to-Face Intervention guidelines:

One progress note per face-to-face contact is required documenting the emergency care and assessment services provided to an individual. It should include, in summary form:

- Identified issue or precipitant to crisis contact;
- Issues addressed or discussed;
- Collateral contact information as solicited or available;
- Observations made by the clinician;
- The clinician's assessment of the issues/situation including mental status and lethality/risk potential;

- Disposition or plan resulting from the crisis intervention;
- Psychiatric consultation, as clinically indicated.

It is acceptable to document telephone and face-to-face Emergency Care and Assessment Services in a log book only if all documentation requirements are present.

Rate:

To be costed periodically and published in memos.

Cost Center: 57 – Emergency Service
Location Codes:

03 = School 12 = Home 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility
53 = DA/SSA Site 98* = PNMI 99 = Community

* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: G01
Procedure Code for Medicaid Billing: H2011 + Modifer **ET** and (Billed under the MH Clinic Child Provider number)

Cost Center: 22-ISB
Location Codes:
03 = School 12 = Home [21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility (Rare)]
53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: G01

Procedure Code for Medicaid Billing: H2011 + Modifier **HE** and (Billed under the MH Clinic Child Provider number)

Cost Center: 23 – Access
Location Codes:
03 = School 12 = Home 21* = Inpatient Hospital (Rare) 23* = Emergency Room
32* = Nursing Facility (Rare) 53 = DA/SSA Site 98* = PNMI 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: G01
Procedure Code for Medicaid Billing: H2011 + Modifer **ET** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six
Location Codes:
03 = School 12 = Home 21* = Inpatient Hospital (Rare) 23* = Emergency Room
32* = Nursing Facility (Rare) 53 = DA/SSA Site 98* = PNMI 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: G01
Procedure Code for Medicaid Billing: H2011 + Modifier **HK** + Modifier **ET** and (Billed under the MH Clinic Success Beyond Six Provider Number)

Clarifications:

A face-to-face or telephone emergency care and assessment service lasting less than 15 minutes cannot be reimbursed.

Emergency care and assessment services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan.

No matter how many clinicians are involved at the same time with an individual or significant others during a crisis, only one clinician's time will be reimbursed. If two separate services are provided that require unique qualifications (e.g. medication management that can only be provided by medical personnel and emergency care services that is provided by a different qualifying clinician), each clinician may bill only for the time spent in their specific service.

If the majority of the emergency care and assessment services were provided in the office, the location code of the mental health center should be used.

During an emergency care and assessment service, it would be legitimate to include time spent transporting an individual. However, a clinician's travel time to or from the emergency scene is not reimbursable.

10. Crisis Stabilization and Support Services (Emergency Community Support)

Definition:

Crisis Stabilization, Support, and Referral Services are focused and ongoing support services provided to children, their families, or their immediate support system that may be time-limited, but necessary to maintain stability or avert destabilization of an expected psychological, behavioral, or emotional crisis. Services are provided to children experiencing mental health crisis as evidenced by: (1) a progressing change in behavior with negative consequences for well-being; (2) declining or loss of usual coping mechanisms; or, (3) increasing risk of danger to self or others. Crisis stabilization services are face-to-face services in an environment other than a child's home. Support and referral includes triaging aftercare needs, supportive counseling, skills training, symptom management, medication monitoring, crisis planning, and assistance with referrals from crisis stabilization in a child's home or by phone. These services are available 24 hours a day, 7 days a week.

Limits:

DDMHS Medicaid reimbursement is limited to a minimum of 15 minutes (2 units) and a maximum of eight (8) units per eight hour period. There is a daily limit of $500.00 for all services per client.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency or provided by staff who, based on his/her education, training, or experience and under the supervision of an enrolled physician or Medical Director affiliated with the Designated Agency, is authorized as competent to provide the service.

Documentation Requirements:

Crisis stabilization and support service needs must be documented upon admission, per shift and/or per 8 hour period of crisis stabilization, and upon discharge for all emergency community support services. Other Medicaid services provided during the crisis stabilization period must follow the documentation requirements for that service. Crisis stabilization and support services should include, in summary form:

Admission Documentation

- Precipitant crisis or behavioral/psychiatric decompensation (e.g. observation of behavior supporting crisis stabilization);
- Assessment of treatment needs or anticipated benefits of proactive clinical intervention;
- Plan for treatment (e.g. issues to be addressed or discussed);
- Physician consultation and agreement with treatment plan.

Per shift and/or 8 hour period of ongoing crisis stabilization

- Observations made of the child (e.g. behavioral or psychiatric indicators for ongoing crisis stabilization);
- Interventions and child's response;
- The clinician's assessment of the issues/situation/risks;
- Ongoing plan for crisis stabilization.

Discharge Summary

- Observations of child's current behavior and presentation;
- Issues addressed or discussed or skills developed in the course of service;
- The clinician's assessment of the child's response to crisis stabilization;

- Follow-up plan (e.g. appointments, supports, medication change, etc.)

It is acceptable to document crisis stabilization and support services in a log. If all crisis stabilization and support services documented in a log are provided by the same individual, that staff member would need to sign the page only once.

However, if other staff members enter notes periodically in the log, they would need to sign their own individual notes. The log sheet should be placed in the clinical record for purposes of audit.

Rate:

To be costed periodically and published in memos.

Cost Center: 58 – Emergency/Crisis Beds 22-ISB 23 – Access **(commonly used for child crisis stabilization services)**

Location Codes: 12 = Home 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: G01 if services are provided in the child's primary living situation or by phone (support/referral)

G02 if services are provided in another crisis stabilization facility (crisis stabilization)

Procedure Code for Medicaid Billing: H2017 + Modifer **ET** and (Billed under the MH Clinic Child Provider number)

Clarifications:

If crisis stabilization and support service admission and discharge occur within the course of an 8 hour period, documentation may abbreviate admission, shift, and discharge information into a summary overview note to reflect the brief course of care.

Crisis stabilization services billed per 8 hour period or per day may not bill for other mental health services provided during the time period billed to crisis stabilization services.

Crisis stabilization and support services provided under the supervision of a Medicaid enrolled physician affiliated with a designated agency may be reimbursed without a prescription in the individual treatment plan. Crisis stabilization services documentation should reflect early on that a review with a physician has occurred and a determination made that crisis stabilization services are required.

11. Service Planning and Coordination (Targeted Case Management)

Definition:

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well being of individuals (and their families), and supporting them to make and assess their own decisions.

Service Planning:

Staff Conferences, with or without the child's presence, for treatment-related case discussions, for developing or modifying individual plans of care, for monitoring the appropriateness of on-going treatment, or for the review and determination of current case assignment or reassignment, constitute service planning. Multiple staff members, agencies, and others may be involved in treatment planning activities. Contact with family, guardian, or primary support relationships specific to treatment planning or determining the appropriateness of current services and supports may be service planning and coordination (e.g. phone contact to discuss or inform the child/family of IPC updates or other changes in treatment is a service planning activity) and may be billed.

The designated case manager should be the staff member responsible for setting overall goals and providing service planning activities. If a case manager is away, his or her case should be reassigned to an "acting" case manager. Only the designated or acting case managers may be reimbursed for service planning and coordination services. Notes should be signed by the designated case manager or "acting" case manager.

Service Coordination:

Service coordination involves contact with school personnel and with other providers from agencies or services other than one's own for the purpose of case review or consultation regarding the provision and coordination of services to a specific child. Other service professionals may include: physicians, juvenile justice, law enforcement, SRS workers, and youth organization community representatives. Service Coordination may also occur with family, guardian, or primary support relationships as indicated to build and promote continuity of services between the living and educational environments. Service coordination includes both face-to-face and telephone consultation with other providers.

For clients who are in residential treatment or for hospitalized individuals, discharge planning is part of service coordination. The designated case manager should be the staff member responsible for providing coordination. It includes activities that would re-establish the child in the community. (See residential/billing chart – back of manual.)

Target Population:

Children must meet the following definition of severe emotional disturbance:
A child or adolescent with a severe emotional disturbance means a person who is under 22 years of age and:

- Exhibits a behavioral, emotional or social impairment that disrupts his/her academic or developmental progress or family or interpersonal relationships;
- Has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity;
- Falls into one or more of the following categories, whether or not he/she is diagnosed with other serious disorders such as mental retardation, severe neurological dysfunction or sensory impairments:

1. *children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre and whose emotional reactions are frequently inappropriate to the situation;*

2. *children or adolescents who are classified as management or conduct disordered because they manifest long-term behavior problems including developmentally inappropriate inattention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusals to accept limits, suicidal behavior or substance abuse;*

3. *children and adolescents who suffer serious discomfort from anxiety, depression, irrational fears and concerns whose symptoms may be exhibited as serious eating and sleeping disturbances, extreme sadness of suicidal proportion, maladaptive dependence on parents, persistent refusal to attend school or avoidance of non- familial social contact.*

The content of the record should reflect behaviors outlined above. The information can be documented via clinical assessments, progress notes and Individual Plans of Care. It is not necessary to state in the record that a child has been determined severely emotionally disturbed. It should be evident by the behaviors related in the child's record.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) or a maximum of $500.00 per client per day.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

Service planning and coordination may be documented by each billable service contact or in a separate monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for service planning and coordination should identify:

- Summarize each contact by describing the discussion and its purpose. Identifying treatment modality (e.g. service planning and coordination is inadequate to describe the activity);
- Describe any indications/observations/assessment impacting treatment and describe individual's response if applicable;
- Describe overall outcome or follow-up activity in relation to the individual service plan.

Or

Monthly summary documentation (in addition to billed services print-out) should identify:

- Summary of primary service planning and/or coordinating activities consistent with treatment goals;
- Summarized observations of case management contacts that may impact treatment;
- Assessed effects of service planning and coordination activities and any progress toward treatment goals;
- Ongoing needs and plan for case management services.

It is acceptable to document service planning and coordination in a log-type format. Clinicians providing multiple interventions in a day (e.g. a school environment) where it may be impractical to provide per intervention documentation in the treatment setting, the clinician may summarize service planning and coordination activity in a daily log. These logs can be separate, but must be available for purposes of audit. If the service planning and coordination entries on a log sheet are provided by the same individual, that staff member would need to sign the page only once. However, if other staff members log service planning and coordination services on the log sheet, they must sign their individual notes.

Rate:

To be costed periodically and published in memos.

Cost Center: 19 – Success Beyond Six
Location Codes:
03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility]
53 = DA/SSA Site [Rare-98* = PNMI] 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21, 32, 98 – service planning and coordination is allowed only for discharge planning within 45 days of discharge. Billed service hours must be identified as such in record documentation.]

Cost Center: 22-ISB
Location Codes:
03 = School 12 = Home [Rare - 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility 53 = DA/SSA Site] 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21, 32, 98 – service planning and coordination is allowed only for discharge planning within 45 days of discharge. Billed service hours must be identified as such in record documentation.]

Cost Center: 23 – Access
Location Codes:
03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility]
53 = DA/SSA Site [Rare-98* = PNMI] 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21, 32, 98 – service planning and coordination is allowed only for discharge planning within 45 days of discharge. Billed service hours must be identified as such in record documentation.]

Cost Center: 26 - CUPS
Location Codes:
03 = School 12 = Home [Rare - 21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility] 53 = DA/SSA Site [Rare - 98* = PNMI] 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21, 32, 98 – service planning and coordination is allowed only for discharge planning within 45 days of discharge. Billed service hours must be identified as such in record documentation.]

Cost Center: 62 – Home Providers
Location Codes:
03 = School 12 = Home 23* = Emergency Room 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 67 – Community Supports and Service Planning
Location Codes:
03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility]
53 = DA/SSA Site [Rare-98* = PNMI] 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21, 32, 98 – service planning and coordination is allowed only for discharge planning within 45 days of discharge Billed service hours must be identified as such in record documentation..]

Cost Center: 71-JOBS
Location Codes:
03 = School 12 = Home [Rare - 21* = Inpatient Hospital] 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations
[NOTE: For location codes 21– service planning and coordination is allowed only for discharge planning within 45 days of discharge. Billed service hours must be identified as such in record documentation.]

Cost Center: 22-ISB 23 – Access 26 - CUPS 62- Home Providers
67 – Community Supports and Service Planning 71 - JOBS

MCIS Service Code: A01

Procedure Code for Medicaid Billing: T1017 + Modifier **HE** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six

MCIS Service Code: A01

Procedure Code for Me dicaid Billing: T1017 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

Children who receive services through the Home and Community-based Waiver are not eligible for service planning and coordination.

Service planning and coordination services may be provided and reimbursed when a client is in a hospital or institution (public or private) for up to forty-five (45) hours during the course of treatment and prior to discharge when there is no duplication of service between the institution and the designated agency and the services are discharge planning/transition/aftercare coordination only. If more than forty-five (45) hours of discharge planning/transition/aftercare coordination are required, prior written authorization must be obtained. Discharge planning/transition/aftercare coordination is considered part of effective community reentry and the responsibility of the designated case manager. If service planning and aftercare coordination services are combined with community support for the purpose of discharge planning/transition/aftercare coordination, the collective total of the two service modalities may not exceed 45 hours or duplicate the service between the institution and the designated agency. Billed service hours must be identified as such in record documentation.

Service planning and coordination may be provided simultaneously with other clinic services, but only one service can be billed.

When multiple clinicians provide service planning and coordination to a child, only one clinician can bill for service planning and coordination.

Service planning and coordination does not include vocational activities.

12. Community Supports (Specialized Rehabilitation Services)

Definition:

Community Supports are specific, individualized and goal oriented services to assist children (and their families) in developing skills and social supports necessary to promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues..

Accessing and utilizing community services and activities may include the development of those skills that enable a child to seek out, clarify, and maintain resources, services, and supports for more independent living in the community, including communication and socialization skills and techniques.

Advocacy and collateral contacts may include collateral contacts with family, area resources and services, or significant others to insure an effective treatment environment for the child. The Medicaid eligible child must be central to such services. Collateral contacts can be provided either face-to-face or on the phone.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations. This activity can be provided either face-to-face or on the phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budget, meal planning, household maintenance, and community mobility skills.

Group community supports may be an appropriate treatment modality and should be prescribed as such in the treatment plan. This intervention strategy/treatment modality should clearly align individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

Limits:

Individual community support is limited to a minimum of 15 minutes (2 units) per session

Group community support is limited to a minimum of 15 minutes (2 units) and a maximum of two (2) hours per day (8 units) and no more than ten (10) hours per week per individual. A group is more than one individual. For group community support, no less than a one staff member to four (4) individual ratio can be present.

Reimbursement for community supports is limited to a maximum of $500.00 per client per day.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

Community supports may be documented by each service provided or with a log and a separate monthly summary. Each program or sub-component must designate which method of documentation it will use.

Per service documentation for individual or group treatment community support should identify:

- Service modality (individual community support or group community support)
- Summarize the discussion/training/skill building provided and its purpose. (Identifying treatment modality (e.g. community support is inadequate to describe the activity)
- Describe the individual's response or clinician's observations.
- Describe overall outcome/results/progress in relation to the individual service plan.

Or

Monthly documentation for individual and group community support should include:

- Attached service report print-out of community support services billed corresponding to the log of community support interventions. The log should identify date of service, service modality, briefly describe the activity/intervention, and be accompanied by the staff member initials.
- Clinicians providing multiple interventions in a day (e.g. a school environment) where it may be impractical to provide per intervention documentation in the treatment setting, may summarize services by individual community support and group community support. Each modality of treatment should be identifiable in the daily summary log.
- Separate monthly summary for individual community support and for group community support if both modalities of treatment are provided in the month.) that includes:
    - Service modality and/or individual or group community support
    - Observations made of the individual or responses to interventions;
    - Assessment of progress toward treatment goal;
    - Ongoing needs for continued intervention and plan.

It is acceptable for monthly summaries of individual community support and group community support to be completed on the same progress documentation, but each must be distinguishable.

Rate:

To be costed periodically and published in memos.

Cost Center: 19 – Success Beyond Six
Location Codes:
03 = School 12 = Home [Rare-21* = Inpatient Hospital 23* = Emergency Room 32* = Nursing Facility]
53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 22-ISB
Location Codes:
03 = School 12 = Home [Rare - 23* = Emergency Room 32* = Nursing Facility] 53 = DA/SSA Site
99 = Community
* Consult Medicaid Manual – these are not billable in all locations
Cost Center: 23 – Access
Location Codes:
03 = School 12 = Home [Rare-23* = Emergency Room 32* = Nursing Facility]53 = DA/SSA Site
99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 26 - CUPS
Location Codes:
03 = School 12 = Home [Rare -23* = Emergency Room 32* = Nursing Facility] 53 = DA/SSA Site
99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 62 – Home Providers
Location Codes:
03 = School 12 = Home 23* = Emergency Room 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 67 – Community Supports and Service Planning
Location Codes:
03 = School 12 = Home [Rare-23* = Emergency Room 32* = Nursing Facility] 53 = DA/SSA Site
99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 71-JOBS
Location Codes:
03 = School 12 = Home [Rare - 21* = Inpatient Hospital] 53 = DA/SSA Site 99 = Community
* Consult Medicaid Manual – these are not billable in all locations

Cost Center: 22-ISB 23 – Access 26 - CUPS 62- Home Providers
67 – Community Supports and Service Planning 71 - JOBS

MCIS Service Code: B01 (Individual)

Procedure Code for Medicaid Billing: H2017 + Modifier **HE** and (Billed under the MH Clinic Child Provider number)

MCIS Service Code: B02 (Group)

Procedure Code for Medicaid Billing: H2014 + Modifier **HE** + Modifier **HQ** and (Billed under the MH Clinic Child Provider number)

Cost Center: 19 – Success Beyond Six

MCIS Service Code: B01 (Individual)

Procedure Code for Medicaid Billing: H2017 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

MCIS Service Code: B02 (Group)

Procedure Code for Medicaid Billing: H2014 + Modifier **HK** + Modifier **HQ** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

Individual community support service is service provided to one individual. Activity focused on one individual and utilizing "peer mentoring", does not constitute an individual service. (see Field Questions and Clarifications Section VIII)

Group community support is service provided to more than one individual.

Community support may be provided simultaneously with other services (e.g. an emergency worker is providing emergency care and assessment services and another staff member is providing community support), but only one of the services can be billed.

Psychosocial and other contributory information gathered through activity performed by non-qualified mental health clinicians for purposes of Diagnostic Assessment, may be billed as community support service. An eligible clinician must still provide clinical diagnosis and interpretive summary/formulation for the completed Diagnostic Assessment.

Vocational and educational service activities cannot be billed as community supports.

Transportation costs are included in the community support service rate. For example, if a staff member transports a child to a community activity as part of treatment, transportation cannot be billed in addition to community supports.

Time in transport of a client is reimbursable only if a treatment service is provided during transport (e.g. supportive counseling occurs during transport).

Only the active therapeutic interactions in the course of total activity time are reimbursable as community support service. (see Field Questions and Clarifications Section VIII)

Community support services may be provided and reimbursed when a client is in a hospital or institution (public or private) for up to forty-five (45) hours during the course of treatment and prior to discharge when there is no duplication of service between the institution and the designated agency and the services are discharge planning/transition/aftercare coordination only. If more than forty-five (45) hours of discharge planning/transition/aftercare coordination are required, prior written authorization must be obtained. Discharge planning/transition/aftercare coordination is contributory to effective community reentry and the responsibility of the designated case manager. If community support is combined with service planning and aftercare coordination services for the purpose of transition/aftercare coordination, the collective total of the two service modalities may not exceed 45 hours or duplicate the service between the institution and the designated agency. Billed service hours must be identified as such in record documentation.

13. C.E.R.T. (Concurrent with Education; Mental Health Rehabilitation and Treatment)

Definition:

Therapeutic behavior services concurrent to education (community support in a school setting) assists individuals, their families, and educators in planning, developing, choosing, coordinating and monitoring the provision of needed mental health services and supports for a specific individual in conjunction with a structured educational setting. Services and supports include planning, advocacy and monitoring the well being of individuals in the educational environment, and supporting individuals and their families to make, sustain, and follow-through with decisions relevant to their mental health needs in an educational setting. Concurrent to the educational services provided by educational staff are specific, individualized and goal oriented services provided by mental health staff either one-to-one or in a group setting and assist individuals in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships.

Service Planning:

Service planning includes educational team conferences and case discussions or contact with family, guardian, or primary support relationships, with or without the child's presence, to design or redesign individual plans of care, to monitor and determine the appropriateness of on-going treatment and/or to review and determine the appropriateness of current services and supports. Contact with multiple disciplines and/or agencies may be involved in service planning.

Service Coordination:

Service coordination includes both face-to-face and telephone consultation with other professionals. Service coordination involves contact with school personnel and other service professionals from agencies other than one's own for the purpose of case review or consultation regarding the provision and coordination of services to a specific child. Other service professionals may include: physicians, juvenile justice, law enforcement, SRS workers, and youth organization community representatives. Service Coordination may also occur with family, guardian, or primary support relationships as indicated to build and promote continuity of services between the living and educational environments.

Therapeutic Behavioral Services (Rehabilitation and Treatment):

Rehabilitation and treatment services are specific, individualized and goal oriented services provided either one-to-one or in a group setting which assist individuals in developing skills and social supports necessary to promote positive growth. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships.

Daily routine skills can include scheduling, planning, and organizing activities in a manner that promotes success in the educational environment. Active skill building opportunities during the course of the school day may relate to communication, social interactions, adaptive behavior, healthy choices, and coping skills.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for more independent function. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations.

Support to develop those skills necessary for the student to identify, engage in, and maintain more independent function in community-based activities, including social behaviors, accessing and utilizing community social, leisure and essential public services, and community mobility skills.

Collateral contacts reflect the day-to-day service delivery discussions with educators and or other school-based clinicians regarding implementation, direct interventions, skill building, counseling or consultation with family, legal guardian, or

primary living support relationships to insure effective treatment of the individual. The Medicaid individual must be central to such services. Collateral contacts can be provided either face-to-face or on the phone.

Target Population:

Children must meet the following definition of severe emotional disturbance:
A child or adolescent with a severe emotional disturbance means a person who:

- Exhibits a behavioral, emotional or social impairment that disrupts his/her academic or developmental progress or family or interpersonal relationships;
- Has impaired functioning that has continued for at least one year or has an impairment of short duration and high severity;
- Is under 22 years of age;
- Falls into one or more of the following categories, whether or not he/she is diagnosed with other serious disorders such as mental retardation, severe neurological dysfunction or sensory impairments:

1. *children and adolescents who exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre and whose emotional reactions are frequently inappropriate to the situation.*

2. *children or adolescents who are classified as management or conduct disordered because they manifest long-term behavior problems including developmentally inappropriate inattention, hyperactivity, impulsiveness, aggressiveness, anti-social acts, refusals to accept limits, suicidal behavior or substance abuse.*

3. *children and adolescents who suffer serious discomfort from anxiety, depression, irrational fears and concerns whose symptoms may be exhibited as serious eating and sleeping disturbances, extreme sadness of suicidal proportion, maladaptive dependence on parents, persistent refusal to attend school or avoidance of non-familial social contact.*

The content of the record should reflect behaviors outlined above. The information can be documented in clinical assessments, progress notes and Individual Plans of Care. It is not necessary to state in the record that a child has been determined severely emotionally disturbed. It should be evident by the behaviors related in the child's record.

Limits:

Reimbursement is limited to school-based mental health programs approved by DDMHS. Reimbursement is limited to the daily service rate, and not to exceed five services per week. Service must be at least two hours (8 units) in duration to bill the daily rate. All other services may be reimbursed on the same day. There is a daily limit of $500.00 for all services per client. If service is provided in a group, no more than 10 students can be present (except as noted in Field Questions and Clarifications).

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service.

Documentation Requirements:

Concurrent with Education Rehabilitation and Treatment services must be documented each day of service and progress reported in monthly summary note.

The clinical note or log content by day must include a cumulative description of each service (e.g. service planning and coordination, individual supports, and group support) provided. The daily documentation must be included in the clinical record. If the same staff person provides the entries on the daily documentation, that staff member would need to sign the page only once. However, if other staff enter notes periodically on the daily documentation sheet, they must sign their individual entries.

The monthly summary for concurrent to education rehabilitation and treatment services must be completed, evaluating progress, outcomes, and changes in service plan accompanied by the daily documentation. The monthly progress note does not need to provide an accounting of the service encounters given the detail of the daily documentation. The note should reflect an analysis of the client response and progress toward the treatment goals and future planning needs.

Rate:

To be costed periodically and published in memos.

Location Codes: 03 = School only

Cost Center: 19 - Success Beyond Six

MCIS Service Code: B 04

Procedure Code for Medicaid Billing: H2020 + Modifier **HK** and (Billed under the MH Clinic Success Beyond Six Provider number)

Clarifications:

School-based mental health services programs must be approved by DDMHS prior to billing concurrent to education rehabilitation and treatment services.

Children who receive services through the Home and Community-based Waiver may be eligible for a daily concurrent to education rehabilitation and treatment service rate. Mental health services provided in the educational setting must be an identifiable set of services from the treatment services provided through the home and community-based mental health waiver treatment plans.

Service planning and coordination and community support cannot be billed at the same time (during the school day or pertaining to school issues/activity) that a concurrent to education rehabilitation and treatment service rate is provided.

When multiple clinicians provide concurrent to education rehabilitation and treatment services, only one clinician can bill the daily service rate.

Concurrent to education rehabilitation and treatment services for a student does not include vocational activities or education services.

Transportation costs are included in the cost of concurrent to education rehabilitation and treatment services. For example, if a school-based clinician or other mental health agency worker provides transportation to or from school, community support or transportation cannot be billed in addition to the daily rate.

14. Joint DMH – ADAP Program - Service Planning and Coordination (Targeted Case Management) and Community Supports (Specialized Rehabilitation Services)

Adolescents eligible for Medicaid Service Planning and Coordination or Community Supports must meet all of the following requirements:

- DSM-IV diagnosis of substance abuse, substance dependence or substance use disorder NOS (not otherwise specified)
- Receiving substance abuse treatment at a level of care of 0.5 or greater by ASAM placement criteria

Definition:

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Service planning and coordination includes discharge planning, advocacy and monitoring the well being of individuals (and their families), and supporting them to make and assess their own decisions.

Community Supports are specific, individualized and goal oriented services to assist children (and their families) in developing skills and social supports necessary to promote positive growth. These supports may include support in accessing and effectively utilizing community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues.

Accessing and utilizing community services and activities may include the development of those skills that enable a child to seek out, clarify, and maintain resources, services, and supports for more independent living in the community, including communication and socialization skills and techniques.

Advocacy and collateral contacts may include collateral contacts with family, area resources and services, or significant others to insure an effective treatment environment for the child. The Medicaid eligible child must be central to such services. Collateral contacts can be provided either face-to-face or on the phone.

Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. The emphasis is upon advice, opinion or instruction given to an individual to influence his/her judgment and/or conduct in everyday situations. This activity can be provided either face-to-face or on the phone.

Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budget, meal planning, household maintenance, and community mobility skills.

Group community supports may be an appropriate treatment modality and should be prescribed as such in the treatment plan. This intervention strategy/treatment modality should clearly align individual treatment goals, emphasizing interactions and mutuality of issues between two or more individuals, for anticipated benefits of a group intervention.

Limits:

Reimbursement is limited to a minimum of 15 minutes (2 units) per day and a maximum of 10 hours (40 units) per client per week for all Service Planning and Coordination and Community Support service combined.

Staff Qualifications:

The service must be provided either directly by a Vermont Medicaid enrolled physician affiliated with the Designated Agency, or prescribed by a physician or authorized APRN directly affiliated with the Designated Agency and provided by staff of the Designated Agency who, based on his/her education, training, or experience, is authorized by the prescribing physician or Medical Director as competent to provide the service. Services may also be provided by a Certified Alcohol and Drug Counselor (CADC), an Apprentice CADC working under the supervision of a CADC, or a qualified clinician who meets the specification requirements authorized by ADAP.

Documentation Requirements:

Combined services may be documented by each service provided; or with one monthly summary note. Each program or sub-component must designate which method of documentation it will use.

Per service documentation should identify:

- Modality of service provided;
- Summarize each service by describing the discussion/training/skill building provided and its purpose;
- Describe individual's response or clinician's observations;
- Describe overall outcome/results/progress in relation to the individual service plan.

Monthly summary documentation should identify for each treatment modality:

- Summary of major content or intervention themes consistent with treatment goals;
- Observations made of the individual or responses to interventions;
- Assessment of progress toward treatment goal;
- Ongoing needs for continued intervention and plan.

Rate:

To be costed periodically and published in memos.

Location Codes:

Cost Center: 22-ISB 67 – Community Supports and Service Planning
Location Codes:
03 = School 12 = Home [Rare- 23* = Emergency Room 32* = Nursing Facility] 53 = DA/SSA Site
99 = Community
* Consult Medicaid Manual – these are not billable in all locations

MCIS Service Code: A01

Procedure Code for Medicaid Billing: T1017 + Modifier **HF** and (Billed under the DMH/ADAP Provider number)

MCIS Service Code: B01 (Individual)

Procedure Code for Medicaid Billing: H2017 + Modifier **HF** and (Billed under the DMH/ADAP Provider number)

MCIS Service Code: B02 (Group)

Procedure Code for Medicaid Billing: H2017 + Modifier **HF** + Modifier **HQ** and (Billed under the DMH/ADAP Provider number)

Providers will be assigned a unique DMH-ADAP, Children's Substance Abuse (community supports) Services Provider ID to be used for billing Substance Abuse Adolescent community supports services.

Clarifications:

- Designated Agencies must meet all requirements of the Division of Alcohol and Drug Abuse Programs "Statement of Assurances, General Assurances" and "Statement of Assurances, Program Requirements".

- General Funding Requirements:

    1. Funding may be used only for adolescents currently involved in substance abuse treatment. Adolescents are defined as clients under 19 years of age or over 18 but still attending high school for the purpose of Service Planning (Targeted Case Management) and Community Supports (Specialized Rehabilitation) only. This grant may not be used to provide services to adult clients.

    2. Funding may not be used to fund any services other than Service Planning or Community Supports.

    3. Funds may not be reallocated within the grant or for other programs in the provider organization.

    4. Funds are capped at the total Medicaid amount stated on the grant.

    5. This is Fee for Service and all funding will be transferred to the provider from EDS. Funding will cover only eligible services.

- Additional Reporting

    1. Units of adolescent case management provided must be included in the "Case Management" field in the Client Data System (SATIS). Case management should not be recorded for services provided to clients other than those receiving services through this grant.

    2. Additional reporting may be requested in the future. Specific information will be negotiated with the provider at the time of the request.

Adolescent case management programs and documentation for substance abuse clients may be audited by either DMH or ADAP. Subcontractors must be ADAP Approved Providers that may also be audited at the discretion of ADAP.

15. Transportation

Definition:

Transportation services are only for the necessary transportation of individuals, covered by Medicaid, to and from an agency facility in order to receive Medicaid reimbursable services. "Necessary" means that the individual has no reasonable alternative transportation available and, without such transportation, would not be able to receive these Medicaid services.

Limits:

Reimbursement is limited to two (2) one-way trips per day, when at least one Medicaid reimbursable service is provided by the designated agency on the same day.

Staff Qualifications:

Any individual or agency hired or contracted with to provide transportation services, with the approval of the executive director can provide transportation services.

Documentation Requirements:

A driver's log signed by the driver or any other procedure approved by the Department of Developmental and Mental Health Services will suffice.

Documentation that the individual received a Medicaid reimbursable service that day must also exist.

Rate: Transportation rates will be calculated on a per center basis.

Cost Center: 13

MCIS Service Code: I 01

Procedure Code for Medicaid Billing:

T2003 + Modifier **HE** + the MH Clinic Child Provider Number

T2003 + Modifier **HK** + the MH Clinic Success Beyond Six Provider Number

T2003 + Modifier **HF** + the MH Clinic Children's OADAP Provider Number

Clarifications:

Field trips or other transportation provided as part of a medical service are not eligible for reimbursement.

Transportation for a Developmental Services client would be coded using a HW Modifier.

SECTION III

PNMI

A. Private Non-Medical Institutions (PNMI)

PNMI's are under the auspices of Social and Rehabilitation Services (SRS). Regulations are promulgated by, and available from, the Department of Social and Rehabilitation Services (SRS).

A PNMI is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides medical care to its residents. A PNMI for Child Care Services must be licensed by the Department of SRS as a Residential Child Care Facility and have a Medicaid Provider Agreement in effect with the Department of Prevention, Assistance, Transition and Health Access.

Covered services of the PNMI Per-Diem rate (the fee paid, per recipient day, to a PNMI Provider) includes a comprehensive spectrum of mental health care services. Community mental health centers may deliver service planning and coordination or community supports for discharge planning/transition/aftercare coordination, not to exceed forty-five (45) hours prior to discharge provided such billing does not duplicate services of another agency. Billed service hours must be identified as such in record documentation.

SECTION IV

GENERAL CLARIFICATIONS

A. General Clarifications

The following general clarifications apply to all Medicaid reimbursable services.

- If a person is Medicaid eligible, Medicaid services can be billed while the individual is on a pre-placement visit from the Vermont State Hospital (VSH). VSH bills Medicaid for persons who:

  1. Are up to and including age 21 or 65 and older
  2. Are on a certified unit
  3. Are not currently an observation individual
  4. Meet Medicaid eligibility criteria

  And are physically present in a bed at midnight. An individual is considered to be in the community if their bed is unoccupied and VSH will not bill Medicaid. If an individual leaves the hospital during the course of the day, receives services from a designated agency and returns to VSH during the evening, the designated agency cannot bill for those services. Billing status can be verified by calling the VSH billing office.

- No two Medicaid services can be billed to a single individual simultaneously.

- The Federal Government (Medicaid – Title XIX) will not reimburse for services to a Medicaid eligible individual if a non-Medicaid individual receives the same service free of charge. This does not preclude the use of sliding fee scales.

- All mental health Medicaid services may be provided and reimbursed on the same day prior to admission, or after discharge, to an institution.

- Only a psychiatrist may provide Medication Evaluation, Management and Consultation or Medication/Psychotherapy while a client is in a hospital.

B. Mental Health Services Provided to Individuals with Developmental Disabilities

Bill under the **Developmental Services** provider number if:

- The individual is currently receiving other services and/or is an active client of the Developmental Services Program of the Designated Agency.

- Use the Developmental Services procedure code and spread staff time accordingly.

Bill under the Mental Health provider number if:

- The individual is not currently receiving other services from the Developmental Services Program of the Designated Agency and/or is not an active client of the Developmental Services Program of the Designated Agency or a Developmental Services Specialized Services Agency in your area. (see Exclusions and Prohibitions, Section C *****).

- Use the procedure code that reflects the program that provides the service.

If an initial assessment completed by a mental health clinician reveals that Developmental Services would be appropriate for the individual, a referral to the Developmental Services Program should be made.

C. Exclusions and Prohibitions

The following exclusions and prohibitions are in effect for mental health Medicaid services.

- Any individuals, including physicians, serving as community mental health agency staff members may not concurrently provide private services of a similar nature to their community mental health agency clients and bill for those services under the Medicaid program.

- No reimbursement will be made for services provided in the facilities of the Vermont State Hospital, except service planning and coordination (for eligible child clients) and/or community support for discharge planning/transition/aftercare coordination, not to exceed a total of forty-five (45) hours of service prior to discharge. Billed service hours must be identified as such in record documentation.

- Activities with the primary purpose of teaching clients the vocational skills needed for a specific job (i.e. vocational trainer/job coach activities) or other vocationally-related services –

  - Vocational Placement
  - Work Adjustment Training
  - Job Placement/Performance evaluation
  - Vocational Workshop
  - Vocational Counseling
  - Vocational Support Group
  - Vocational Program Administration

- Activities with the primary purpose of education, such as academic instruction or tutorial, typically provided in an educational setting by professional educators.

- No other mental health Medicaid reimbursement shall occur for any client receiving:
  - PNMI services;
  - IFBS services;
  - developmental services or mental health and community-based waiver services (except as noted below ***)**.

***** Children whose services are covered under a Developmental Services Waiver or a Mental Health Waiver may be eligible for additional services if the following conditions are met:

For children covered under either Medicaid Waiver program, Success Beyond Six Medicaid may be billed for only service planning and coordination, individual community support, and group community support for school supports if:

- Services are not duplicative of services or any other supports provided under the Waiver.
- Services must be a specific set of mental health services provided in the school environment.
- Goals and services must be identified in the Individual Plan of Care.

This exception is available for children up to their 22nd birthday. It is not available for adults over 22.

D. Non-Medicaid Reimbursable Services – Adult Service

Service Planning and Coordination (Targeted Case Management) –
(Only Severely Emotionally Disturbed (SED) Children are eligible)

Definition:
Service planning and coordination assists individuals and their families in planning, developing, choosing, coordinating and monitoring the provision of needed services and supports for a specific individual. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, coordinating service providers, and monitoring the well being of functionally independent individuals (and their families), and supporting them to make and assess their own decisions.

Adults enrolled in the Community Rehabilitation & Treatment (CRT) Program may not be billed in addition to a case rate for this service.

Employment Assessment

Definition:
Employment assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.

Employer and Job Development

Definition:
Employer and job development assists an individual to access employment and establish employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

Job Training

Definition:
Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

Ongoing Support to Maintain Employment

Definition:
Ongoing support to maintain employment involves activities needed to sustain paid work by the individual. These supports and services may be provided both on and off the job site, and may involve long-term and/or intermittent follow-up.

Emergency/Crisis Beds

Definition:
Emergency/Crisis beds are emergency, short-term, 24-hour residential supports in a setting other than a person's home. Crisis stabilization services are reimbursable.

Intensive Residential

Definition:
Intensive Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
Definition:
Intensive Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Intermediate Residential

Definition:
Intermediate Residential – Supervised/Assisted Living (by the hour) are regularly scheduled or intermittent supports provided to an individual who lives in his/her home or that of a family member.
Definition:
Intermediate Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
Definition:
Intermediate Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Consultation, Education and Advocacy

Definition:
Consultation, Education and Advocacy services are system-based work done with family and community groups to improve circumstances and environments for targeted DDMHS populations. These services may include community resource development. They are not provided in relation to a specific individual receiving services funded by DDMHS.

Day Treatment or Day Services

Definition:
Day Services are group recovery activities in a milieu that promote wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer centered. This service provides socialization, daily skills development, crisis support and promotes self-advocacy. **[Not for DS use.]**

E. Non-Medicaid Reimbursable Services - Children

Employment Assessment

Definition:
Employment Assessment involves evaluation of the individual's work skills, identification of the individual's preferences and interests, and the development of personal work goals.

Employer and Job Development

Definition:
Employer and Job Development assists an individual to access employment and establishes employer development and support. Activities for employer development include identification, creation or enhancement of job opportunities, education, consulting, and assisting co-workers and managers in supporting and interacting with individuals.

Job Training

Definition:
Job Training assists an individual to begin work, learn the job, and gain social inclusion at work.

Ongoing Support to Maintain Employment

Definition:
Ongoing support to maintain employment involves activities needed to sustain paid work by the individual. These supports and services may be provided both on and off the job site, and may involve long-term and/or intermittent follow-up.

Emergency/Crisis Beds

Emergency/Crisis beds are emergency, short-term, 24-hour residential supports in a setting other than a person's home. Crisis stabilization services are reimbursable.

Family/Home Provider Supports (Respite)

Definition:
Family/Home Provider Supports assist family members, significant others (e.g., roommates, friends, partners), home providers and foster families to help support specific individuals with disabilities. It includes:

Respite (by the hour) services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.

Respite (by the day/overnight) services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care to individuals who cannot be left unsupervised.

Family Education

Definition:
Family Education is education, consultation and training services provided to family members, significant others, home providers and foster families with knowledge, skills and basic understanding necessary to promote positive change.

Consultation, Education and Advocacy

Definition:
Consultation, Education and Advocacy services are system-based work done with family and community groups to improve circumstances and environments for targeted DDMHS populations. These services may include community resource development. They are not provided in relation to a specific individual receiving services funded by DDMHS.

Intensive Residential

Definition:
Intensive Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
Definition:
Intensive Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Intermediate Residential

Definition:
Intermediate Residential – Supervised/Assisted Living (by the hour) are regularly scheduled or intermittent supports provided to an individual who lives in his/her home or that of a family member.
Definition:
Intermedi ate Residential – Staffed Living are residential living arrangements for one or two people, staffed full-time by providers.
Definition:
Intermediate Residential – Group Treatment/Living are group living arrangements for three or more people, staffed full-time by providers.

Day Treatment or Day Services

Definition:
Day Services are group recovery activities in a milieu that promote wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer centered. This service provides socialization, daily skills development, crisis support and promotes self-advocacy. **[Not for DS use.]**

Education

Definition:
Activities with the primary purpose of **education**, such as academic instruction or tutorial, typically provided in an educational setting by professional educators are not reimbursable.

SECTION V

BILLING INSTRUCTIONS

Billing Instructions for Clinical Support Services, Case Management, and Transpo rtation Services

Bills, either paper or electronic, shall be submitted according to procedures established by the Department of Developmental & Mental Health Services (DDMHS).

There is a maximum reimbursable dollar limit per client per day, regardless of the number of services provided. DDMHS will publish daily limits in memo form when they are modified.

Payments and Conditions of Reimbursement

The following conditions of reimbursement shall apply to all mental health Medicaid services.

- Payment fo r mental health Medicaid services will be made at the lower of the actual charge or the Medicaid rate on file. The agency must accept, as payment in full, the amounts received from Medicaid.
- According to Federal Law, all clients must be treated similarly in terms of billing for all services. For example, if a non-Medicaid client is being transported with other clients whose services are being reimbursed by Medicaid, the non-Medicaid client must also be billed. (This does not preclude the use of sliding fee scales.)
- DDMHS retains sole authority to set payment rates.
- Errors must be refunded or adjustments made immediately upon realization that an error in billing has occurred.

For Billing Purposes, the Following Applies

Time/Unit Definitions for services.

(See Clinical Assessment, Medication Management, Partial Hospitalization, CERT Program definitions).

1 minute to 14 minutes	=	1 unit
15 minutes to 30 minutes	=	2 units
31 minutes to 45 minutes	=	3 units
46 minutes to 60 minutes	=	4 units
61 minutes to 75 minutes	=	5 units
76 minutes to 90 minutes	=	6 units
91 minutes to 105 minutes	=	7 units
106 minutes to 120 minutes	=	8 units (etc.)

Any combination of services (except Partial Hospitalization) may be provided to a client, not to exceed the maximum allowed amount per day. Services cannot be duplicated or provided simultaneously.

Place of Service Codes

Following are the codes to be used for Medicaid reimbursement for mental health service providers.

03	-	School
12	-	Home
21	-	Inpatient
23	-	Emergency Room
32	-	Nursing Facility
53	-	Community Mental Health Center
98	-	Private Non-Medical Institutions (PNMI)
99	-	Community

Multi-Service Modifiers

When more than one session of a specific activity is allowed on the same day, the following modifiers should be attached to the appropriate code.

Subsequent, Same Service	-	76
Subsequent, Different Service	-	77

Filing Policy -Claims/Adjustments

Claims and/or adjustments over six months old that have not already been billed to EDS will not be approved for filing except in the following instances:

- The Department of Developmental and Mental Health Services has created a situation which made it difficult or impossible to submit the claim and/or adjustment with the allowed time, i.e., rate change;
- EDS is at fault (documentation required) for the claim and/or adjustment not being processed in a timely manner;
- Retroactive eligibility;
- Other insurance – no response (attempts to receive denial must be documented in writing) the Department will forward requests for overriding other insurance to the Medicaid Division; and/or
- Other insurance – a denial was received after the year filing time and documented attempts were made to receive the denial with the year.
- The agency has been over paid and a recoupment is needed
- Re-submissions – all agency re-submissions must be processed and received by DDMHS within 6 months, but cannot exceed one year from the service date.

Claims and/or adjustments meeting the above criteria, and not more than 1 year old except in the case of other insurance, will be reviewed on a case-by-case basis. Please be advised that any claims and/or adjustments over two years old cannot be considered for payment in accordance with federal regulation.

Third Party Liability

- Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the recipient for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid. It then becomes an issue of recovery. Some examples of third party resources are:

    - Medicare (agencies must accept assignment)

    - Health insurance, including health and accident, but not that portion specifically designated for "income protection" which has been considered in determining recipient and veteran programs, workers' compensation, etc.

    - Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

Waiver of Third Party Billing Sources

The Department of Developmental & Mental Health Services (DDMHS) has approved overriding the third party insurance and Medicare billing for all Service Planning and Coordination services, Community Support services (individual and group), and Transportation. These services can be billed directly to Medicaid.

Medicare "Incident To" Services

The Department of Prevention, Assistance, Transition, and Health Access in communication dated 2/11/02 identified that "Group Behavior Health Practices (including Mental Health Clinics) can bill "incident to" when:

- All conditions for doctoral-level psychologists are met, and
- All staff/workers enrollable by Vermont Medicaid/VHAP have been identified and enrolled, and
- Physician(s) providing drug management have been noted on the enrollment/recertification application.

Subsequent communication from PATH dated 4/4/02 identified that "Community Mental Health Centers are required to follow the guidance of the Department of Developmental and Mental Health Services regarding "incident to…" billing, not the Office of Vermont Health Access guidance for Medicaid services."

As such, and without additional PATH communication to the contrary, guidance is as follows:

CMHC's may bill Medicare "Incident to" services directly to Medicaid, when those services are provided by qualifying clinicians (as previously outlined in this manual) of the Designated Agency. All staff/workers enrollable by Vermont Medicaid/VHAP are encouraged, but not currently required by DDMHS, to be identified and enrolled as qualifying providers.

Services must be rendered in a manner where:

- qualified supervising clinician and/or physician are available for urgent or emergent needs, on-site or via phone;
- qualified, supervising clinicians are available for routine day-to-day operations and oversight in the delivery of treatment and services; and
- supervision is scheduled and regularly occurs (documented 1-on-1 meetings for case review is not required);
- client treatment plans are regularly reviewed and signed by the supervising Designated Agency psychiatrist.

Medicare Waiver – NC Modifiers

NC means a "non covered" service. Medicare/Medicaid eligible recipients may be eligible for reimbursement of one daily clinic service through Medicare. Additional clinic services provided in a day, when not reimbursed by Medicare, are eligible for reimbursement through Medicaid using a NC modifier. Providers who know a service to "not be covered" since Medicaid is a payer of last resort, may bill Medicaid directly by using the NC modifier when appropriate.

Medicare Waiver – NP Modifiers

NP means "no physician" present. Some services delivered to clients who are covered by both Medicare and Medicaid can be billed directly to Medicaid when the Medicare requirement that a physician be present cannot be met. The requirement that Medicare be billed first is "waived".

The following services are covered under this waiver.

- Medication management provided by a nurse.
- Psychotherapy, Diagnosis and Evaluation, Group Therapy, and Emergency Care provided by a qualified clinician who is neither an M.D. an LICSW, or licensed Ph.D.

SECTION VI

MEDICAID AUDIT PROCEDURE

MEDICAID AUDITS

Medicaid field audits will be performed at least annually with every Designated Agency. Medicaid field audits consist of two segments: Mental Health Adult and Children's services. A random sample of all transactions reimbursed by Medicaid will be drawn for the two segments. The sample size will vary for each Designated Agency based on the entire number of transactions that were billed and paid during the fiscal year under audit. Ten percent (10%) will be the allowable error rate. In addition, a 25% sample of the units of service audited may be selected to be traced to the timesheets. The clinical and fiscal (billing records and documents) findings will be compared to each other to verify agreement. The MCIS match will contribute to the computation of the error rate.

A post-audit reconciliation with the fiscal agency (Electronic Data Systems -Federal) must be completed within 30 days unless a formal appeal is in progress. A copy of the reconciliation materials must be sent to DDMHS within 45 days.

If an error rate exceeds the allowable 10%, the Designated Agency must perform a 100% internal audit on the program(s) that are problematic (DDMHS will determine the programs to be included in the internal audit). The internal audit must be completed within six months of the original audit. DDMHS will re-audit at six months or earlier following completion of the internal audit. Should the second audit exceed the allowable 10%, DDMHS reserves the right to do a complete 100% audit of the Designated Agency. Errors must be refunded or adjustments made immediately upon realization that an error in billing has occurred.

The Designated Agency has a right to appeal the results of an audit. The agency has 15 days from receipt of the audit findings to notify the Director of the Division of Mental Health of the agency's intent to appeal. The Director of the Division of Mental Health will arrange an informal meeting within 30 days to hear the appeal. The Director of the Division of Mental Health will notify the Designated Agency within 15 days of the appeal meeting of his/her findings. If the Designated Agency is not satisfied with the findings, the agency may appeal in writing to the Commissioner of the Department of Developmental & Mental Health Services within 15 days. The Commissioner of the Department of Developmental & Mental Health Services will arrange a meeting within 30 days of the subsequent appeal request. The Commissioner of the Department of Developmental & Mental Health Services will notify the Designated Agency within 30 days of the subsequent appeal meeting of his/her determination. The determination made by the Commissioner of the Department of Developmental & Mental Health Services is final.

SECTION VII

TABLES OF MEDICAID BILLABLE SERVICES

FOR

LOCATION/FACILITIES AND/OR FUNDING SOURCE

❖ **ADULT Medicaid Billable Services for the following Locations/Facilities**

Location/Facility	Diagnosis & Evaluation	Individual Psychotherapy	Family Therapy	Group Therapy	Medication Management	Med/ Psychotherapy	Emergency Care and Assessment	Crisis Stabilization	Community Support	Service Planning & Coordination	Partial Hospitalization	DDMHS Medicaid Transportation
School (03)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes***
Home (12)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes***
Inpatient Hospital (21)	Yes*	Yes*	No	No	Yes*	Yes*	Yes*	No	Yes	No	No	Yes***o
Nursing Facility (32)	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes*	No	No	Yes***
Emergency Room (23)	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	No	No	Yes***
DA/SSA (53)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes***
Substance Abuse Treatment Facility (Residential -55)	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	No	Yes**	No	No	Yes***
Correctional Facility (71)	No	No	No	No	No	No	No	No	No	No	No	Yes***
Private Non-Medical Institution (98)	No	No	No	No	No	No	No	No	Discharge Planning (if still a qualifying SED child)*	Discharge Planning (if still a qualifying SED child)*	No	Yes***
Community Location (99)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes***
CRT Program Adult Case Rate	Case Rate											

*Refer to manual clarifications
** Services can be provided to deal with issues other than substance abuse (alcohol and other drugs). Community mental health centers are encouraged to coordinate treatment with the substance abuse treatment facility.
***Reimbursable when not covered by OVHA Medicaid

❖ While a location may be an allowable service site, clinicians must verify compatibility with their reporting cost center locations as well.

❖ **CHILD Medicaid Billable Services for the following Locations/Facilities**

Location/Facility	Diagnosis & Evaluation	Individual Psychotherapy	Family Therapy	Group Therapy	Medication Management	Med/ Psychotherapy	Emergency Care and Assessment	Crisis Stabilization	Community Support	Service Planning & Coordination	**Joint OADAP**	C.E.R.T.	DDMHS Medicaid Transportation
School (03)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes***
Home (12)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes***
Inpatient Hospital (21)	Yes*	Yes*	No	No	Yes*	Yes*	Yes*	No	Discharge Planning*	Discharge Planning*		No	Yes***
Nursing Facility (32)	Yes*	Yes*	No	No	Yes*	Yes*	Yes	No	Discharge Planning *	Discharge Planning*		No	Yes***
Emergency Room (23)	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes***
DA/SSA (53)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes***
Substance Abuse Treatment Facility (Residential -55)	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	Yes**	No	Discharge Planning **	Discharge Planning*		No	Yes***
Correctional Facility (71)	No	No	No	No	No	No	No	No	No	No		No	Yes***
Private Non-Medical Institution (98)	No	No	No	No	No	No	No	No	Discharge Planning*	Discharge Planning *		No	Yes***
Community Location (99)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes***
Children with Waiver Funding	No	Yes****	No	Yes****	No	No	Yes	Yes	Yes****	Yes****		Yes****	Yes***

* Refer to manual clarifications
** Services can be provided to deal with issues <u>other than</u> substance abuse (alcohol and other drugs). Community mental health centers are encouraged to coordinate treatment with the substance abuse treatment facility.
***Reimbursable when not covered by OVHA Medicaid
****Reimbursable services must be a separate and identifiable set of services over-and-above the Medicaid Waiver services

❖ While a location may be an allowable service site, clinicians must verify compatibility with their reporting cost center locations as well.

SECTION VIII

FIELD QUESTIONS

AND

CLARIFICATIONS

Field questions specific to Adult Clinical and Support Services from Section I

Specialized Community Support Page 26

Question: There is a slight difference in the definition. In comparing to the old manual, it appears that some language of service planning and coordination is introduced. Impact on services?

Answer: That is correct. The variant is intentional since service planning and coordination is available to SED children only. Elements of more intensive support service were introduced for adults, but are not intended to prompt any significant impact to existing services. The definition may be useful to DA's with more complicated AOP individual cases.

Partial Hospitalization Pg. 29

Question: Partial Hospitalization: "highly structured (5-16 hours/day)" Prior regulation time was at least two hours per day.

Answer: The timeframe was incorrect and inconsistent with the Partial Hospitalization definition: 'highly structured (5-16 hours/day)" is the correct timeframe.

Question: There were some changes in the limits - at least 3 sessions per week and a session must be at least 5 hours in duration (up from 2).

Answer: Correct as corrected.

Question: What is expected if a person attends two days of Partial Hospitalization, but not the third in the week. Can it be billed?

Answer: Partial Hospitalization is a level of care prescribed by a physician. Reimbursement for services is subject to providing all of the services necessary for that level of care. If a client does not participate in that level of care, an alternative service plan should be developed and services provided and billed accordingly.

Question: Requires daily documentation and must include these additional elements: progress toward treatment plan goals and ongoing indications/rationale for partial hospitalization.

Answer: That is correct.

Question: Procedure Code for Medicaid Billing was changed.

Answer: Correct.

Question: Under the Clarifications, an attendance sheet listing the hours of service is acceptable as long as it meets all the requirements for timesheets.

Answer: That is correct and in addition to daily progress documentation.

Field questions specific to Children's Clinical and Support Services from Section II

Service Prescription and Documentation Page 34

Question: The new manual specifies that "each individual's goals, objectives, and interventions" should be "clearly stated". This requirement would benefit from some additional clarification. Given that individual goals and interventions are required for individual family members does this new requirement mean that the "Family IPC" should consist of charts for each individual member that are housed in a family chart and summarized in a single IPC?

Answer: No, not necessarily. The intent is appropriately identifying focus of treatment. If the family is the focus of treatment and all or some family members are Medicaid eligible, then individual and family treatment may be provided and documented appropriately. If a child is the only member of the family who is Medicaid eligible, but the family is clearly the focus of treatment in plan and/or notes (as is often the case with very young children), then a family IPC must be written to reflect the treatment plan, goals, objectives and outcomes as they relate to the client within the family.

The concept of "Family IPC" is useful in reframing the services that may be provided to the non-client family members on behalf of the client, to reflect the central focus on the client. Medicaid requires that the named client must be the central focus of billed service. Goals and progress documentation must follow, substantiating that the client is the focus of treatment. Goals that do address services not directly provided to the named client may be appropriate if they are tied back to the client as the central focus of the services provided. Also, for very young children, V61.20 Family-child relational problem is available as a billable Medicaid diagnosis for children, ages 0-6 years for these situations.

Question: Are a complete intake, diagnosis and assessment required for each family member whose individual goals and interventions are included in this Family IPC?

Answer: No, not necessarily. Individuals receiving treatment do require a treatment plan. Good clinical practice suggests that treatment plans result from a comprehensive assessment of needs formulating a treatment plan.

Question: How does the Department advise that we separate the individual's record from the family record in the case of divorce (i.e. to insure that HIPAA rules do not allow an ex-spouse to access her/his former spouse's protected health care information)?

Answer: Each agency has a defined practice for maintaining confidentiality and has developed policy to assure HIPAA compliance. DA Legal counsel should be consulted so that policy addresses this level of detail.

Service Planning and Coordination Page 55

Question: Service coordination. Narrow as written. Can we add informal supports? Or where else in the document is this included?

Answer: Informal supports are included in "family, guardian, or primary support relationships". Any other "informal" supports should be supported by documentation.

Question: The definition of Service Planning was somewhat expanded from the old manual to include contact with others. The piece regarding children in residential placements was moved to Service Coordination.

Answer: The clearer definition does not represent any significant expansion over current practice.

Question: Logs. What is the audit standard for the logs? What should be included in the log? Could we have an example?

Answer: The log should identify date of service, service modality, briefly describe the activity/intervention, and be accompanied by the staff member initials.

Question: In the "monthly service documentation" section there are two visually distinct parts – the 4 bulleted items (summary, summary, assessed, ongoing) and the narrative section that follows (It is acceptable …). Is the new requirement for documentation either the 4 bullets ***OR*** the narrative? Or, is the new requirement the 4 bullets ***AND*** the narrative?

Answer: The documentation requirements specify either "per service documentation" or "monthly summary documentation" initially. The addition of "or" will again be emphasized between the bulleted per service documentation and the bulleted monthly documentation.

Community Support Page 59

Question: It seems a daily log is required for community supports but not for service planning/coordination?

Answer: That is correct.

Question: The first clarification would benefit from some additional clarification. It states: "Individual community support is service provided to one individual. Activity focused on one individual and utilizing "peer mentoring" or engagement does not constitute an individual service." Community support involves using the community. An important part of a child or youth's community is her/his peers. Having peers is a frequent goal for youth and children. Having appropriate peers for their children is a frequent goal for parents. In treatment, time with a peer of peers may be used as contingent reward for children who may have a treatment goal of "improving peer relations" or "increasing positive time in the community" or "develop supports outside the home". Does this clarification mean that when a CMHC staff member is providing community supports designed to meet the aforementioned goals those supports are not billable services if a peer is present and/or part of the therapeutic intervention?

Answer: It depends. If the CMHC staff member is using a dynamic of group interaction with one or more other children and the clinician is engaging with another child or children, then Group Community Support is the medium. If the IPC indicates peer contact or behavior self-control as a goal and clearly outlines objectives as to what is planned and expected between the client and the CMHC staff member, then individual support may be appropriate. A clinician working with a child in a setting of peers may be individual treatment. If, on the other hand, the CMHC staff member is passively observing or present with the child and peers with no active intervention occurring, no treatment is provided.

Question: In therapeutic day care best practices define "typically developing peers" as an important component to providing services to less typically developing children (i.e. those CMHCs serve). If a staff member is interacting with a client and that typically developing non-client is part of the interaction as part of the treatment plan do the new procedures mean that any time a peer is present the service is not billable?

Answer: No, see above.

Question: In the educational community peers surround CMHC clients. Interactions with those peers provide the basis for the supports provided to those clients. If a child has an interaction with a peer and the CMHC staff member uses that interaction to provide feedback and support to the client, the above clarification could be interpreted to mean that the staff member's intervention is no longer a billable service. If that is the case then the cost of Success Beyond Six programs will increase dramatically. In summary, it seems as if this clarification could be interpreted to mean that the Department is less than supportive of serving children in a "normal" setting. The incentive seems to be to segregate clients from their non-client peers to insure that services provided are billable and consequent fiscal costs to community partners are controlled.

Answer: Incorrect interpretation.

Question: Also, the procedures are clarified as follows: "Only active therapeutic interactions in the course of total activity time are reimbursable as community support service. Passive observation is not a reimbursable service activity." In many settings CMHS staff are called upon to begin a period of time with a client by reminding him/her of a particular goal or goals. The staff member then actively observes the client for that period of time. The staff member may or may not be required to intervene during that period depending on the client's treatment needs. At the end of that period the staff member would relay what s/he observed of the client during that period and give the client feedback on his/her success and/or needs for subsequent behavior change. Whether that active observation (that includes no time intervening) meets the procedures standards as active may benefit from additional clarification.

Answer: See Above. Active observation and its measured or defined component features should be offered if mental health treatment Medicaid is requested. Availability of treatment staff also carries administrative or program non-treatment related costs. As with any community support activity, 100% of the associated time is not necessarily therapeutic service delivery time. DA staff members have always been expected to differentiate total time from administrative or non-therapeutic time. This expectation is unchanged.

Question: The new procedures seem to significantly increase paperwork requirements. By requiring either logs and monthly summaries or per service documentation direct service staff will be required to take time more time to complete required paperwork. For staff working in school communities this may require time away from providing the services schools contract for. Such a requirement will decrease schools' satisfaction with the services provided. It may be helpful for the Department to offer a written explanation of the rationales for these changes for CMHCs to share with our community partners.

Answer: Documentation is a basic administrative requirement for all billed activities. Per service documentation is still a Medicaid standard and an available option. The monthly summary option is a flexible documentation alternative, but must provide sufficient information for audit trail of billed Medicaid services. Service billing summaries verify only billing of Medicaid. A monthly summary must document and support the level of Medicaid billed services. Logs are specifically required for only children's community support services. In non-CERT educational settings, where services may be high, daily summary logs are allowable options.

Question: Administrative staff will be required to devote significantly more time to monitoring paperwork to insure that it is complete and error free, supervisory staff will be required to devote more time to overseeing staff around paperwork issues, and Department staff will be required to read significantly more paperwork when reviewing Agency's for quality, designation and the like. . The new procedures will likely require a significant investment of administrative time. Staff will need extensive re-training in either logging services or in producing acceptable per service documentation. Filing will increase significantly. The space required to retain records is likely to increase. The amount of time to monitor records for completeness, accuracy and compliance is likely to increase.

Answer: Administrative, training, and supervisory requirements accompany procedure changes. Documentation is not a new requirement, but changes in expectation will require an initial investment in orientation. We disagree that disproportionately more time will be required long term. Fee-for-Service Medicaid audits are not tied to Designation processes.

Question: It seems as if the Department is providing an administrative incentive to use per service documentation. Per service documentation requires roughly the same amount of behavior as a log without the additional requirement of writing a monthly summary, the filing of that summary and monitoring that summary. Per service documentation was the method required by the Department for a number of years. It was given up in favor of monthly summaries because the summaries provided what was seen as a better method of reflecting what occurred in the life of a consumer and the effects of services on that life.

Answer: We disagree with the interpretation. Per service documentation requires a summary of the therapeutic activity, response, and progress related to the IPC. A log requires a list of therapeutic interventions that are then summarized monthly.

Concurrent to Education Rehabilitation and Treatment Page 63

Question: Will there be a single service code for both Specialized Community Supports and Service Planning/Coordination in this service?

Answer: The code is H2020- modifier HK.

Question: By approval required by DDMHS prior to billing, do you mean on a case by client case basis or on a school by school basis? Wouldn't this rate alter the total amount of matching funds?

Answer: Approved school programs have a daily rate that is established based on program costs.

Question: Is it true that other outreach services, i.e. emergency and non-school community supports and service planning are prohibited from being billed when the bundled school rate is billed? May all other services be billed, i.e. med checks, psychotherapies, etc., on the same day as a C.E.R.T. service?

Answer: See page 64 under limits. "All other services may be reimbursed on the same day."

Question: Is C.E.R.T. required to be implemented or is there a choice not to bill it?

Answer: Programs are not required to implement CERT.

Question: If C.E.R.T. is paid at a daily rate based on two hours of attendance, what does group have to do with it?

Answer: C.E.R.T. services may be provided either one-to-one or in a group setting. The daily rate is only a method of payment, the form of treatment provided still needs to have appropriate documentation – individual and/or group summary documentation.

Question: How about a staff to kid ratio instead of a gross number? A staff to student ratio is needed as the kids at some agencies start their day with a community meeting. Community meeting is a forum to discuss issues that may have presented themselves on the previous day or issues of the upcoming day. During that meeting as many as 5 or 6 staff are present with as many as 16 kids. For some of these kids that meeting needs to be included in their two hours of service. Some kids leave to spend time at the sending school. In order to bill on these kids who are transitioning out of the program we need to be able to count the community meeting time.

Answer: The "no more than 10 clients in a group" is federal guidance. Group services can be provided in a 1-to-10 ratio, but may not exceed 15. For only school services billing C.E.R.T. and holding a forum such as "community meeting", the ratio as described above will be allowable toward the per diem.

Question: Clarifications - "When multiple clinicians…only one clinician can bill the daily service rate"
You're billing on a kid being there. There is a bunch of people in the rate. What does this mean?

Answer: The intent is that one daily rate is billed per child. If the rate is generated by clinician billing, then only one clinician may bill per child. If the program establishes a different billing procedure, this clarification may be unnecessary.

Question: Would C.E.R.T. have to be a separate modality on the treatment plan?

Answer: Services to be provided need to be identified under CERT.

Question: If indeed these services include both service modalities (service planning and coordination and community support), will there be only a single monthly note required (along with the logs)?

Answer: CERT requires a monthly summary for CERT services. Each service modality must be summarized monthly.

Question: Since multiple clinicians may deliver services to the same client at different times of the day in different locations, would each clinician have to complete a daily log of interventions since it would be logistically impossible to use the same log?

Answer: If that is the case, then yes.

Question: And all of these logs would have to be attached to the print out of services along with the monthly summary written by the case manager?

Answer: Yes.

Joint DDMHS/OADAP Program Page 66

Question: Limits "40 units per week." Why not $500/day limit as in other rehab?

Answer: This is unchanged from the previous manual and specific to the OADAP funding level.

Clarifications applicable to both Adult and Children from Sections I and II

Eligible Providers Page 5

Question: Paraphased - Degree of oversight and supervision for sub-contractors seen as excessive.

Answer: Designated Agencies and/or supervisory personnel may be unclear regarding the DA accountability for contracted service arrangements or collaborative service agreements that allow billing Medicaid through the Eligible DA. Contracted entities providing and billing services and receiving reimbursements from Medicaid through a Commissioner designated agency are predicated on Eligibility for Participation standards that must be met.

Question: Paraphrased - Draft guidelines for NP's seen as too prescriptive by DDMHS.

Answer: The role of the Designated Agency Advanced Practice Nurse is included in this manual revision as an option for DA's who wish to further utilize the expertise of this discipline as outlined in the current guidelines.

Service Prescription and Documentation Page 6 and 34

Question: PRN or "as needed". Past practice had been to use the terms such as "Weekly or PRN". Is this not adequate with this version.

Answer: That is correct. In the IPC we are looking for planned services that the psychiatrist has ordered and the team has provided. This could be "weekly", "3 times per week", "monthly" or at whatever frequency is planned as appropriate. PRN or "as needed" services are not planned and should not appear on the IPC. PRN is not intended to capture all possible services that may be provided, only those services that may periodically, as part of a comprehensive treatment plan, be provided. A pattern of PRN services, occurring regularly over time, should be amended to reflect planned services in the IPC.

Question: If a service is provided that was not ordered on the IPC, can it be billed?

Answer: Considerable discussion occurred on this question in both regions (e.g. If a service isn't prescribed, but is provided because it is clinically appropriate) and required further exploration and clarification. If billing was allowed by DDMHS, clinicians would need to identify the treatment in progress notes and why the treatment was indicated without being part of the service plan. An addendum to the treatment plan would be required otherwise. CMHC Records and Billing representatives were quick to express concern that they would be unable to adequately monitor documentation and billing requirements. Therefore, an addendum to the treatment plan is required prior to billing for services that have not been prescribed. Emergency care remains exempt from this requirement.

Question: Clarification of DMH's definition of "frequent" would be helpful, as well as "within what time frame"?

Answer: "Frequent" would be a service pattern of daily to weekly service occurrences that are sustained over a period of several weeks (e.g. two progress reporting periods) without an addendum to an existing treatment plan.

Question: Outcomes. Are measurable objectives an acceptable substitute for anticipated outcomes? Could these two be merged? They seem to be nearly the same thing.

Answer: Not necessarily. An objective may provide the measure of a change or an observable anticipated behavior pattern that is not an overall outcome or indicator of success. This may be successfully merged, but they are not the same thing.

Question: Outcomes: It appears that the outcome would be stated in the Goal statement. Is this a repeat of that?

Answer: Expected and/or realized outcomes should be clearly stated as such on an IPC. Goals are often stated in the client's words and seldom include outcomes. Goals also tend to be long-term where outcomes reflect short-term or incremental goals.

Individual Plan of Care Page 7 and 35

Question: Prohibition of checklists has the unintended consequence of eliminating tools which are meant to enhance clinical thoroughness. See for example the attached mental status checklist used by MD's and PNP's during an initial evaluation.

Answer: The prohibition of checklists is specific to IPC's. Checklists for other purposes may be acceptable and are not prohibited.

Question: "IPC should be completed within 30 days" or by the 4th visit. The 30 days was not in last years regulation. Is this an error or revision?

Answer: This timeframe is a revision. The intent is development of timely IPC's. IPC's should be completed by the 4th planned service. Again, emergency care is not a planned service.

Question: In our agency, the clinicians write the IPCs and the physician signs/approves the prescription for services. Often the physician has not yet seen the client at the time of signing the plan and would not know if Med/therapy was indicated. How does DMH wish to see this service prescribed?

Answer: As with any treatment service introduced following the development of an individualized plan of care, the change in service would be addendumed to the treatment plan.

Question: Regarding IPC clarifications, a new IPC after 6 months of no contact is mentioned, is a new D+E also required?

Answer: A re-evaluation should occur. This may or may not result in a new D&E.

Question: In a situation where there is a recent D+E on file, might there be a possibility of a "D+E" addendum for a re-admit whereby a clinician could provide updated information without having to complete the entire criteria a second time?

Answer: This is perfectly acceptable.

Question: Location 99: Community – Under Medicare we have to state where the actual location was. Is this a requirement with this code?

Answer: No. In efforts to support code simplification, "community" location is acceptable in meeting the requirement.

Question: General Record keeping requirements. Is an individual log entry a "support note" that must be signed?

Answer: For purposes of general records requirements, support note standards reference per service documentation. Log entry documentation is defined on page 60 under monthly documentation. The log should identify date of service, service modality, briefly describe the activity, and be accompanied by the staff member initials. A signature is only required once to identify initials.

Question: White out is now formally prohibited.

Answer: It has been formally prohibited since July, 2002.

Clinical Assessment Page 10 and 37

Question: Regarding documentation requirements, does "done within the past six months" mean you must complete a new D+E every 6 months?

Answer: No, this means that all the information on the D&E must be collected within 6 months. It may be completed in an hour or two, or, in some cases, it may take several months to gather all the information.

Question: It looks like we will now be allowed four 15 minute units or one hour per year for a diagnosis and evaluation. This is very inadequate. D&E's typically take at least 1.5 hrs. Also, both psychiatry and psychotherapy need to do d&e's in a year.

Answer: The detail on page 9 may have been overlooked or may be unclear. Each D & E is considered one unit in its entirety. The sum of time spent on the D & E is billed as one unit and the re-imbursement rate is calculated based on the fee schedule for 15 minute increments. There is no set dollar amount for a D&E, the service will be "paid as billed" according to the time spent in 15min. intervals. There is a **minimum** limit of two 15-minute billing units (30 minutes) for each D&E. Up to four D&E's may be done annually, even if each one requires multiple 15-minute billing units. Billing and coding representatives from each agency were involved in the creation of this D&E unit definition.

Question: There is a format change from 5 to 9 elements. We need TA in adapting the requirements to crisis service D&E. How often must the 9 elements be done?

Answer: The nine elements are required to bill a D&E. The four modified elements are the identification of strengths, needs, summary, and recommendations. These elements should typically be considered in crisis service D&E documentation currently.

Question: Why is element #6 separate from #9?

Answer: Element #6 refers to needs or deficits as voiced by the client, #9 is treatment recommendations made by the clinician.

Question: "Qualified clinicians obtaining information for purposes of clinical assessment or clinical intake may not be reimbursed as any other services" This becomes problematic when an assessment is underway and for some reason it cannot be completed with all of the required elements of the D&E. This could occur more frequently now as the required elements have gone from 5 to 9.

Answer: If, for some reason, a D&E cannot be completed, it should be sited as "incomplete" with an explanation and the service will be "pay as billed" for a D&E.

Question: "Administratively required assessment…that do not meet clinical assessment and service prescription requirements are not reimbursable" Does this indicate ones that do not meet the medically necessary requirement?

Answer: If evaluations occur as a result of an order of the court, the evaluation is not eligible for Medicaid payment – it is administratively required. DDMHS does provide reimbursement to DA's for guardianship evaluations requested by the courts through DDMHS.

Individual Therapy Pages 12 and 40

Question: Expanded on the definition of Individual Therapy. Is there greater accountability given the expectation to resolve symptoms and increase function?

Answer: Efforts to resolve symptoms and increase function have always been the expectation. Therefore, there is no greater accountability.

Family Therapy Page 15 and 42

Question: The Procedure Code for Medicaid Billing has been changed and there are different ones for when a client is present or not present.

Answer: That is correct.

Question: Regarding clarifications, does the family member who you are billing under to need to be present in each session you are billing for? For example, if you are seeing a couple and billing for family therapy, do they both need to be present in each session?

Answer: Generally, the answer is yes, especially in the scenario described. Infrequently, individual work may supplement family therapy and the reasons should be noted to explain the potential discrepancy with billed service.

Question: Is it possible to provide family therapy when there is only one person in the room or when the identified client is not in the room?

Answer: Generally the answer is no. The same condition as above applies.

Question: How should we bill for one hour of family therapy provided to four children by two clinicians, if the two clinicians (each clinician sees one child and two children are not clients) provide the service? Can each clinician bill for one hour of service for each of the two child clients?

Answer: One hour of family therapy is provided by the two clinicians. One hour of family therapy should be billed. Billed service may be attributed to one child client or divided between the two child clients for the one hour of service.

Group Therapy Page 16 and 44

Question: How about a ratio of staff to clients instead of cap on number of clients? E.g. “Group therapy sessions are limited to a maximum ratio of ten individuals per clinician.”

Answer: A ratio is now available. The “no more than 10 clients in a group” rule is federal guidance and should not be altered substantially.

Medication Evaluation, Management, and Consultation Page 18 and 46

Question: Regarding staff qualifications, does "a licensed nurse" mean a nurse practitioner specifically? Does “licensed nurse” include LPN as well as a RN and APRN?

Answer: The State Board of Nursing determines the scope of practice and practice guidelines for nurses. Whether registered nurse or nurse practitioner, each can operate only within their degree and license qualifications for this service. This section addresses the primary services of physicians, registered nurses, advance practice nurse practitioners, and physician assistants operating within the scope of their professional licenses.

Question: Does this include psychiatry residents?

Answer: Contrary to regional meeting comments and in reviewing the DDMHS Medicaid correspondence archives, the answer was and remains "No" at this time. As outlined in the 6/14/01 DDMHS "Billing for Physician services who are training at a hospital but who are in a community placement at a Designated Agency" Memorandum, there would be no DA billing for physicians training at a hospital who are placed in a designated agency community setting.

Question: "Medication evaluation, management, and consultation services may be done in a group setting" ... [proposed Procedures Manual, page 19 under "Clarifications"] - Currently medication management (chemotherapy) is not provided (not covered or paid) in a group setting. Is this a new covered service?

Answer: No, it is consistent with current manual (see pages 15 & 16 of January 1, 2002 procedures manual).

Question: Created "Group Services" and "Emergency Services" cost centers and codes. The Group Service cost centers and MCIS Service Code are the same as the previous codes, but the Procedure Code for Medicaid Billing has been changed. Since Emergency Service is new, there are new codes all around.

Answer: Incorrect interpretation. No new services, cost centers, or codes have been created. These reflect existing services, cost centers, or codes. Cost centers are identified for reporting specific services given new procedure codes and modifiers. Emergency care is not a new service.

Medication/Psychotherapy Service Page 20 and 48

Question: A physician or Psychiatric Nurse Practitioner must provide service.

Answer: That is correct

Question: What will the rate be for "Medication/Psychotherapy service"?

Answer: The proposed rates will be consistent with OVHA reimbursement for physicians and nurse practitioners. 90805 is $72.73 (30 minutes), 90807 is $95.87 (60 minutes), and 90809 is $124.79 for (90 minutes). The codes will not be available until December 2003. These represent new services which were added in an effort to identify and properly compensate for physician-provided services. DDMHS will monitor these reimbursement rates and consider rate adjustments as we move forward.

Emergency Care and Assessment Page 22 and 50

Question: "EC and Assessment …may be face-to-face or provided by phone." Is email included under the phone category?

Answer: No.

Question: Emergency Care & Assessment Services references can be provided by telephone. What is the length of time standard needed to bill when providing service on the phone? Is it 15 minutes like face to face or is 30 minutes or some other standard?

Answer: The standard is now the same as face-to-face emergency care contact.

Question: Services provided under the care of a Medicaid enrolled physician may be reimburse without a prescription for an IPC.

Answer: Read Clarifications on page 23. The intent is to reassure providers that emergency services will be reimbursed as needed.

Question: The log referenced for Emergency Care conflicts with the documentation requirements.

Answer: The documentation requirements have been corrected and must be met via a log format as well.

Crisis Stabilization Page 24 and 53

Question: Crisis stabilization. Who is this meant for? Is this service only for placement in a residential crisis situation?

Answer: Currently, home and community based waiver program and the 1115B waiver program for CRT provides resources to support crisis stabilization programs. Service providers need a mechanism for payment of crisis stabilization services and Fee-for-Service Medicaid does not pay for crisis beds. Community support services have been used for payment of crisis stabilization services. No new cost center or code has been created. Cost centers are identified for reporting specific services given new procedure codes and modifiers. The new procedure code is a community support service code with an emergency modifier and should be used to identify this service. The payment for crisis stabilization is for the service provided, not the placement or the bed.

Question: The same question about billing via phone on this service as under definition it references "in a person's home or by phone".

Answer: The units are consistent with the Emergency Care and Assessment definition.

What is the rate for this service? Is this an all-inclusive service?

Answer: The current limits are set with consideration of the current per unit community support care rate of reimbursement. Units billed per 8 hours are inclusive of all service provided.

Question: What about someone admitted to a crisis bed but does not stay overnight? Would service be billed as Emergency Services instead of crisis stabilization? Day rate or hourly rate?

Answer: No. Crisis stabilization services are delivered in an environment other than the person's home. The service is reimbursed at rates consistent with up to, but not exceeding the maximum per day allowable, to support facilities providing this level of care. As such, allowable unit maximums have been set to reflect the pattern of services for this level of care. The provider must determine which service and supports are most appropriate since only 8 units of crisis stabilization service may be billed in an 8 hour period and no additional mental health services may be billed for the same time period.

Question: If admission, stabilization, and discharge occur within an 8-hour period, then documentation may be abbreviated into a summary overview note. Crisis stabilization billed per 8-hour period or per day may not bill for other services provided during stabilization. Stabilization provided under a physician's supervision by be reimburse without and IPC in place.

Answer: This is consistent with crisis care. The admission plan for treatment documentation and physician authorization constitutes a plan of care.

Question: Reimbursement for this new modality (Crisis Bed) appears to be any of the following: Per hour, and/or per 8-hour shift, and/or per diem basis. A per diem (bed-day) approach makes the most sense, in order to follow industry billing practices and to be consistent with MSR reporting/costing analysis.

Answer: The billing limits support what is current practice and offer definition and guidance for the existing service.

Community Supports Page 26 and 59

Question: Limits for individual support now has a minimum of 15 minutes.

Answer: Represents only a clarification of previous manual omission.

Question: "Collateral contacts can by provided either face-to-face or on the Phone:" Does phone include email?

Answer: No.

Question: Along with vocational services, educational services can not be billed under community supports.

Answer: Educational and vocational services have never been Medicaid reimbursable. Each manual is an improvement on the last. We are striving to convey requirements in as clear and concise a manner as possible.

Section III: PNMI

No Clarifications

Section IV: General Clarifications

Question: Section D: Non-Medicaid Reimbursable Services - Adult Service, under the Emergency/Crisis Beds, Crisis Stabilization services are noted as being reimbursable. Emergency/Crisis Beds are not reimbursable to MH clients. Since the Crisis Stabilization definition is essentially an E-Bed service, shouldn't this be stricken from the manual?

Answer: No. Currently, home and community based waiver program and the 1115B waiver program for CRT provides resources to support crisis stabilization programs. Service providers need a mechanism for payment of crisis stabilization services and Fee-for-Service Medicaid does not pay for crisis beds. Community support services have been used for payment of crisis stabilization services. No new cost center or code has been created. Cost centers are identified for reporting specific services given new procedure codes and modifiers. The new procedure code is a community support service code with an emergency modifier and should be used to identify this service.

Question: Section E: Non-Medicaid Reimbursable Services - Children, Education was added to the list.

Answer: That is correct.

Section V: Billing Instructions

Question: Multi-Service Modifiers have been changed.

Answer: That is correct, 76 and 77 are available.

Question: Medicare "Incident To" definition has been eliminated and refers to "Consult with Medicare for clarification as needed." **DDMHS must help clarify this since most services provided are billed 'Incident To' a physician. DA's currently operate under less than clear guidelines regarding "Incident To" billing (e.g. DDMHS' 4/10/2002 letter to John Dick). If DA's are bound to the Medicare "incident to" rules, then there will be a tremendous risk of cutback to services since virtually every Fee-For-Service client will need to be seen initially and periodically either by a physician or a Medicaid credentialed (ergo licensed) staff provider.**

Answer: DDMHS originally deleted this section at the request of the Vermont Council acting on behalf of the Designated Agencies. The Designated Agency providers have requested that this information be put back into the DDMHS Medicaid Manual. Language, consistent with PATH communications, has been re-introduced in this section.

Question: Medicare Waiver NP and NC modifiers have been eliminated and reference is made to "Consult with Medicare for clarification as needed." DDMHS needs to reincorporate this section into the manual, otherwise the DA's will have to assume that Medicare must be billed prior to seeking Medicaid benefits for services (e.g. chemotherapy provided by a nurse, services provided by a clinician who does not meet the Medicare credentialing threshold).

Answer: DDMHS originally deleted this section at the request of the Vermont Council acting on behalf of the Designated Agencies. The Designated Agency providers have requested that this information be put back into the DDMHS Medicaid Manual. Language has been re-introduced in this section.

Question: Added a section on Filing Policy - Claims/Adjustments. Claims/adjustments over 6 months old that were not already billed to EDS will not be approved for filing unless: DDMHS created a situation that made it difficult/impossible to file in allowed time, EDS is at fault, retroactive eligibility, other insurance - no response, other insurance - denial after a year, agency overpayment or recoupment, or re-submissions. Claims/adjustments meeting the above criteria will be reviewed on a case-by-case basis. Claims/adjustments over 2 years old cannot be considered for payment.

Answer: That is correct.

Section VI: Audit Procedures

No questions.

Section VII: Tables

No questions.